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HEALTH CARE FOR THE RURAL ELDERLY: INNOVATIVE APPROACHES TO PROVIDING COMMUNITY SERVICES AND CARE

JOINT HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

AND THE

SUBCOMMITTEE ON HUMAN SERVICES

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

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HEALTH CARE FOR THE RURAL ELDERLY: INNOVATIVE APPROACHES TO PROVIDING COMMUNITY SERVICES AND CARE

MONDAY, SEPTEMBER 18, 1989

SENATE SPECIAL COMMITTEE ON AGING,
HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN SERVICES,
SELECT COMMITTEE ON AGING,
Bangor, ME.

The committee and subcommittee met, pursuant to notice, at 10 a.m. at the Bangor House, 174 Main Street, Bangor, Maine, Hon. William S. Cohen (acting chairman, Senate Special Committee on Aging) and Hon. Olympia J. Snowe (acting chair, Subcommittee on Human Services, House Select Committee on Aging), presiding.

Present: Senator Cohen and Representative Olympia J. Snowe.

Staff present: Winthrop Cashdollar, Marc Hartstein, and Natalie Cannon, Daryce Minzner, House Select Committee on Aging.

OPENING STATEMENT BY SENATOR WILLIAM S. COHEN, PRESIDING

Senator COHEN. Good morning ladies and gentlemen and welcome to our hearing on the subject of health care for the rural elderly and innovative approaches to providing community services and care.

This hearing is convened under the joint auspices of the House Select Committee on Aging, Subcommittee on Human Services, of which Representative Snowe is the ranking Republican member, and the Senate Aging Committee, of which I am a senior member.

Maine is renowned for the independence of the people who live here, and I would add that this is especially true of Maine's elderly. They have been proud of what they have been able to do for themselves, their hard work, and the fruits of their labor.

Once again, I am proud to point out that my own father is a good example of this. At the age of 80, he continues to work 18 hours a day in our family bakery with the able assistance, I might say, of my mother, whose age continues to remain a national security secret.

If I disclosed that I would be in deep trouble here.

I recently spent some time at the bakery as a temporary employee under the tutelage of my father, and I must say that it was only temporary. But I know that he would never voluntarily give up his hard work. It is part and parcel of his pride and independence.

As a member of the Senate Aging Committee, I try to be sensitive to a common theme that must run through society's and Government's consideration of the needs of our senior citizens. That theme is the need to ensure the greatest degree of independence possible for our elders and to help them preserve their dignity in the years that were once considered to be golden.

Nothing is more crucial to preserving the independence of our elderly than making sure they have the best possible health and health care.

Access to adequate health care has to be a part of rural living for our senior citizens, because if it is lacking, those who need care suffer without it or find themselves going to lengths that elderly residents in urban and suburban America would never dream of. The physical and emotional toll of this can be devastating.

The difficulties of maintaining access to quality health care in rural parts of the country affect all who live in remote or isolated areas. However, it is the rural elderly who bear the brunt of these difficulties. This is true in part because the elderly represent a much greater portion of our Nation's rural population than our urban population.

While the elderly comprise about 12 percent of the population of this country, they account for more than 25 percent of the rural population. Of course, the elderly are also often in much greater need of health care services than the rest of the population.

On average, individuals who are 65 or older go to the hospital twice as often and stay in the hospital twice as long and require twice as many prescription drugs as younger individuals. Americans 65 or older typically visit a doctor more often than younger individuals—provided, of course, that there is a doctor that they can get to. One of the most critical problems facing the rural elderly is the scarcity of doctors and other health professionals.

Nationwide, rural communities are short some 4,000 doctors. Currently in Maine, in specific communities designated by the Federal Government as health manpower shortage areas, there is a critical need for more primary care physicians for rural practice.

Access to physicians with specialized skills and training required to treat many conditions to which the elderly are especially prone is extremely limited. In all of Aroostook County, by way of example, there is only one neurologist. Soon there will be only one psychiatrist in the county, and currently there are no rheumatologists there.

Over the years, Maine has relied heavily on the National Health Service Corps program to help recruit and support health professionals like Dr. O'Keefe and Dr. Pelli. Since its establishment in 1971, the Board has brought some 132 health professionals to the people of Maine. But now the program is no longer in a strong position to bring doctors and other medical professionals into the many areas that desperately need them.

Not only is it often difficult for the rural elderly to obtain the services of a doctor, they also have to worry about continued access to their rural community hospitals. Olympia has worked hard on this issue. She has visited many rural hospitals during the past year and therefore, I will leave a longer discussion of these issues to her.

Let me point out that at a time when virtually all hospitals are grappling with financial difficulties due to health and manpower shortages, soaring costs, decreasing inpatient population, and lagging Medicare reimbursement, rural hospitals find these problems compounded by economic and demographic circumstances that threaten their very existence.

Over the course of the last year and a half, two of Maine's rural hospitals had to close their doors. Twenty out of a total of 42 of Maine's hospitals are classified as rural. These facilities serve almost 40 percent of Maine's people. They are struggling financially. According to the Maine Hospital Association, during 1988 Maine's 20 rural hospitals lost a total $4.2 million, an average loss of more than $200,000 per facility. The average occupancy rate during 1988 within Maine rural hospitals was 57 percent, well below the national average of 65 percent.

Although rural hospitals play a crucial role in meeting the health care needs of the elderly, clearly many remote communities will not have a hospital nearby. Most often it then falls to community or rural health centers to meet the primary health care needs of many rural elderly.

Nationwide, there are over 900 community health centers and clinics serving the uninsured, Medicare and Medicaid patients. Elderly residents of Maine's communities have come to rely extensively on the primary and preventive health care services available through their community health centers and rural health clinics.

Indeed, these facilities comprise the backbone of the health care system for some of Maine's most remote and isolated areas. Our hearing today is going to give us a chance to hear some of the more promising innovative approaches that Maine health centers are bringing now to rural health care.

In spite of the importance of these health centers to providing access to health care services, their ability to do more to meet the needs of the rural elderly is strained by limits on their grants from the Public Health Service and by the level of Medicare and Medicaid reimbursement.

To the extent that Medicare/Medicaid reimbursement to the health centers is inadequate, the centers must use scarce Federal grant dollars to subsidize Medicare/Medicaid. This is simply inappropriate and circumscribes the ability of the health centers to provide more extensive health care services. I hope we have a chance to explore this question thoroughly today.

Today we are going to hear from rural doctors, rural elderly people, officials of rural hospitals, representatives of Maine's community health centers and rural health clinics, and others who are going to speak on behalf of the rural elderly and health care consumer.

We hope to hear, not only the problems facing rural elderly patients and the health care providers that serve them, but also of the innovative steps that are being taken, and there are many, and that should be taken to adapt our current health care system for meeting the medical needs of these elderly in rural and remote areas.

I would like to yield to Representative Snowe who has been truly a leader in the field of helping to bring adequate health care to our senior citizens.

STATEMENT BY REPRESENTATIVE OLYMPIA J. SNOWE

Representative **Snowe**. Thank you.

First of all, I am very pleased that we are able to be here today, and I am pleased that Senator Cohen and I have been able to jointly sponsor this session. Bill has worked on the issues concerning the senior citizens in Maine, particularly their health and well-being, and has been both wideranging and effective during his tenure in Congress. He has consistently provided services of the first order to Maine's elderly. So I am especially glad to be with him today.

By merging our interests in health care to the rural elderly, today's hearing provides us with a unique opportunity to probe across a wide spectrum of problems, new and old, that result in a lower level of care for many older rural residents.

The plain and often arbitrary fact is that the rural elderly pay a real cost in their health solely because of where they live. Reasons for this shortfall in care abound: the aging of the rural population, the centralization of health care services, changes in health care practices, the decline in the rural economy, and Federal policies which shun the special needs of the rural health care system.

All of these combine to create the unfair and unacceptable circumstances in which rural elderly simply do not have access to the health care they require.

For example, in Maine and across the Nation, rural hospitals face a precarious situation. Over the past few months, I visited six of these hospitals in my district to see firsthand with what they must cope and how they are doing.

In 1988, Maine's rural hospitals experienced a total financial shortfall of $4.2 million. This was an average operating loss of $212,228 per hospital. The result—Maine lost two small rural hospitals between the spring of 1988 and the spring of 1989.

One key factor in this fiscal squeeze is the fact that the Federal Medicare Program pays rural hospitals at a lower rate than urban hospitals—when many expenses are actually similar. And Medicare has also failed to provide adequate protection for the smallest and most vulnerable rural hospitals.

But the dilemmas of rural hospitals are not wholly the creation of the Medicare system, there is an assortment of interacting factors. So, in order to survive, rural hospitals are looking increasingly toward innovative approaches for providing services and care.

In my visits to rural hospitals in Maine, I have seen how they are diversifying services and how they have created collaborations with other facilities to strengthen their financial conditions.

Since these efforts are instrumental in helping the hospitals meet new challenges, the Federal Government must work toward providing incentives for these activities and removing barriers to their development.

There is a very real concern, however, that some of the smallest rural hospitals may not survive long enough to adapt to the changing health environment. These facilities are often located in isolated areas far from other hospitals, so we can ill afford to lose them.

Now, as Senator Cohen described, the problems of the rural health care delivery system are by no means the exclusive problems of hospitals. For example, there is an acute need for physicians and other health care professionals. In 1988, there were 1,292 rural areas across the country with health manpower shortages, 21 of which are in the State of Maine.

At the same time, however, the Federal Government has scaled back significantly the National Health Services Corps and other programs which enlist individuals to serve in isolated areas. Without such assistance, many rural areas and towns have little hope of securing needed health professionals.

We have all heard the old line, "Is there a doctor in the house?" Well, the question in rural areas has become, "Is there a doctor in the town?" The answer increasingly is no.

In examining the rural health care delivery system, we must focus as well on the vital role played by rural health care centers. Given the current and future changes in health care, we are going to see a continuing escalation of dependency upon these centers as medical providers. As such, we have a responsibility to help ensure that they are able to meet that challenge.

A decision by an older person to live in a rural area must not be a decision to accept inferior health care. To ensure that this is not the case, our ongoing efforts must be channeled in new directions.

I am confident that the testimony you will hear today will provide vital insight for building a health care partnership which will provide our rural elderly with the access to the health care they require.

I want to thank all of those who are here today and all of those who will be submitting written testimony as part of the hearing record. You are all performing a worthy service and we welcome what you have to say. Thank you.

Senator Cohen. Our first panel this morning consists of two rural physicians and two senior citizens from Maine. These are the doctors who are on the front line of providing service, as well as individuals who are on the front line receiving that service.

I want to explain a little about the backgrounds of two individuals. I have to turn the clock back a bit in talking about Greg O'Keefe—back to 1983. During that year I had dozens of letters that started to pour into my office and they all came from a little island called Vinalhaven. It got my attention. The letters all said, "Don't let the Government take away Dr. O'Keefe." Then I began to look into the matter and I found that Greg was the only doctor on Vinalhaven, and that he was absolutely beloved by his patients and the residents of the island.

He had come to the island back in 1975 as a part of the National Health Service Corps, which sends doctors out to remote areas. In 1983, much to the dismay of his patients, the Corps decided they wanted to pull him out of Vinalhaven and put him into a desk job in Washington.

I must tell you, rarely, in all of my years in Congress have I ever received a greater outpouring of affection for an individual. I finally was able to take a trip up to Vinalhaven and I saw it with my own eyes why it was that this man was so beloved by his patients. I received letters from teenagers, from people in their nineties, everyone telling me what he had meant to their lives.

This is also an issue we're going to discuss this morning. It would be hard to get another doctor to come to the island and the nearest medical facility is in Rockland, which is a 2-hour boat ride away. So, the prospect of losing a doctor, especially one who is as committed and talented as Greg, was terrifying, literally, to everyone on the island.

Luckily, we were able to overturn the Government's ruling and he stayed on the island.

When Olympia and I began to plan for this hearing, Dr. O'Keefe was probably the first person we thought of as one who could really bring a message to this committee about what kind of service he was able to provide for the people who live on Vinalhaven.

Dr. O'Keefe could obviously double his income if he went to Boston or New York, but he has chosen to stay on Vinalhaven. I think he is an example of the very best we have in medicine and public service. We are all looking forward to hearing from him today.

So, Greg, both Olympia and I are very, very thankful that you are able to be with us.

I will take a moment to introduce all of the panelists and then we will hear from each of them.

Like Greg O'Keefe, we have another doctor testifying this morning. He has dramatically demonstrated a commitment to serving patients in rural Maine, despite the availability of more lucrative jobs elsewhere.

In fact, Roger Pelli's case is so unusual, he attracted the attention of our national media. As I mentioned to him just a few minutes ago, I met a gentleman at the airport, who said, "That doctor from up north, how can I get in touch?" I said, "What do you want?" He said, "I want to give him some money. I want to help him stay up there." So Good Morning America and ABC World News Tonight has had some good effect already.

Dr. Pelli worked as a physician's assistant at Ashland for 5 years and decided he wanted to become a full-fledged doctor. But he found out that the expense of becoming a full-fledged doctor would run him something in the neighborhood of $100,000. He then hit upon a plan that one local official called a cross between "I have a dream" and "let's make a deal."

Dr. Pelli suggested that the people in Ashland and the surrounding towns impose a modest tax upon themselves for paying the cost of his medical education, and in return he promised to return after school and practice medicine in Ashland for at least 8 years. Well, the towns did, in fact, impose that tax and Roger Pelli was accepted at the University of New England's College of Osteopathic Medicine at Biddeford, Maine.

While in school, he simply flourished as a student. I think he graduated second in his class. He kept all of the people up in Ashland posted about his progress with letters and postcards which in turn were posted in various places around the community. Now, he has returned to Ashland as the only doctor serving 3,000 people in the area.

I must say that once again this represents a tremendous effort on your part, Dr. Pelli, like Greg O'Keefe.

I also want to add my thanks to Judith Hickley from the Aroostook Valley Health Center in Ashland for giving Dr. Pelli the day off so he could be here.

We asked Dr. O'Keefe, does he have a patient who would make a good witness at this hearing. He said, "I've got one who would be a superstar if we can get her to come."

Well, we're thankful for Vera Johnson for coming here today to share her perspective as an older person on the health care problems that older people face in rural areas. Mrs. Johnson, who will celebrate—this is not a national security matter—she will celebrate her 94th birthday next month. She has lived on Vinalhaven since 1904. She is extremely close to her family of 2 children, 5 grandchildren, 15 great-grandchildren, and 4 great-great-grandchildren. Mrs. Johnson has owned a restaurant, was the president of Vinalhaven Garden Club for many years, and she has been involved in virtually every activity on the island. We're grateful to Mrs. Johnson and to her family members for making the trip with her.

I will tell you the first words she said to me, she said, "I always look to see how your suit looks on you when I see you in person and on television." I don't know what the significance of that is.

I will forewarn all of you, she has promised not to tell you how she became a Republican many, many years ago.

I will discuss that later, Mrs. Johnson.

Finally, we have Roy Gallagher from East Machias. I have known Roy for more than 15 years, and he has always been the man to call in Washington County if I need information and feedback on current issues and events.

Roy is a modest 78 years old. He has been retired about 10 years from a very successful mining business. He has his own experience with needing health care, being very far away from the services, and he is also familiar with experiences of many of his fellow citizens. He is a prominent and active member of the community.

Roy, we are delighted to have you with us today.

Dr. O'Keefe, if you would like to begin.

STATEMENT OF DR. GREGORY O'KEEFE, VINALHAVEN, ME

Dr. O'Keefe. First of all, thank you very much for inviting me to participate in this hearing. I will try to be brief; and I will do my best.

I look upon the physician serving in rural Maine as having the greatest opportunity of all: to enjoy the doctor/patient relationship that existed in years gone by, and at the same time, have all the advantages of modern technology and pharmacology.

We all know what kind of miracles are possible in health care today. Therefore, lack of that medical care represents a greater deprivation now than at any other time in our history. Deprivation of medical care strikes the very young and the very old the hardest. Therefore, these groups benefit the most from having medical services available.

On our isolated little island of Vinalhaven, the shortage of medical care would be easy to recognize. But I think in many other rural areas and in many urban areas there is an equally crucial shortage of medical care, that is more difficult to recognize. There are also special population groups in addition to the elderly who are deprived; refugees, AID's victims, prisoners, and disaster victims.

The basic medical equation—at least from my point of view—includes the doctor, his patient, and the wherewithal to take care of that patient. Lacking the physician or extender, the equation cannot be complete.

In 1972, the National Health Service Corps was founded to complete the equation. It supported physicians for the underserved populations of our Nation. It was effective and it grew to a corps of several thousand physicians and allied health personnel.

Unfortunately, a variety of factors led to a decreasing size and mission for the NHSC. I think one important factor may have been the so-called GMENAC study of physician supply. At that time, a physician glut was predicted, and although I can't really comment on population demographics, I do know that all that a patient cares about is his own medical care and having his own physician that they can call and be treated by.

Many areas of Maine cannot easily find, attract, or retain a physician or extender. Elderly persons, therefore, cannot obtain just basic and preventive medical care, let alone crisis care.

What is keeping the physicians of today from serving rural and other underserved groups? I feel that the conventional wisdom of medical peer groups today may be playing the greatest role of keeping doctors from sticking to or going to small or isolated places. I won't elaborate, but let me list some of these myths: social, professional, and education deprivation; malpractice fears; malpractice economics; income; professional backup; vacation coverage; or, what I feel is the primary cause, the unfounded fear that all of the above are true.

Rural practice can be tolerated. It can even be enjoyed as a lifetime occupation. My own belief based on similar fears that I had 15 years ago, is that almost no amount of cajoling, wining, and dining can entice a young physician to come to a rural area for long. There is bound to be argument about this, but my own decision to remain in a rural area was based on the realization that the conventional wisdom was incorrect and the appreciation and service of the health care that a provider could bring to a rural area, or to an isolated area.

I make several suggestions based upon the theory and actual practice of the National Health Service Corps. First, strengthen the manpower of the NHSC. You can accomplish this by service and time-related incentives to volunteers. Perhaps there could be educational loan repayment after 2 years of service, perhaps coupled with outright grants to physicians, or tax credits to those physicians who invest in or buy their own rural practice.

But if volunteerism does not succeed, I would suggest compulsory service requirements for all physicians, not only for rural areas, but also for the other underserved population groups in this country, and offer incentives to those who wished to remain after they had served their service requirement.

I believe that agencies other than towns should also get into physician procurement. Specifically, I think that the area nursing agencies and county health agencies could serve their patients better if they had a physician who was available to make those house calls, to do chemotherapy without forcing patients to leave home or leave their nursing homes, and to save the homebound or nursing home bound patient from long and tiring ambulance transportation to secondary or tertiary medical centers. General and family practitioners can be instructed by specialists in chemotherapy, and thereby save their patients an awful lot of time and transportation.

Community health centers and hospitals should be encouraged in their efforts, and I would hope that they could be helped to improve their economic outlook by changing the Medicare reimbursement formula, as mentioned before.

One other suggestion that I have, to make medical care more available and more affordable for the elderly, is to impose nationwide mandatory assignment for all Medicare claims. I believe that this would not decrease the available services, especially in rural areas, because that service is going to be performed whether or not the claim is mandatorily assigned. I believe that such an imposition could not hurt, in fact would help the ailing doctor/patient relationship.

An elderly patient who is denied ready access to physician care appropriately feels insecure, a heightened sense of anxiety, alienation, and eventually despair.

I strongly feel if the doctors won't come, let us create incentives, and if they still don't come, let us draft them and give them incentives to stay there. Once a physician has the opportunity to fully appreciate the unique opportunity of rural practice, the special satisfaction of serving the elderly, and being able to live in Maine, he will serve his patients and himself very well.

Many thanks for allowing me to be here today.

Senator **Cohen**. Thank you very much, Dr. O'Keefe.

Dr. Pelli.

STATEMENT OF DR. ROGER PELLI, AROOSTOOK VALLEY HEALTH CENTER, INC., ASHLAND, ME

Dr. **Pelli**. Thank you again for inviting us. This is a great opportunity to discuss in a very direct way what we think are the problems and suggestions for getting some solutions. Again, I thank you for letting me be here.

Dealing with the elderly in northern Maine, I find a major theme underlying all of their thoughts and that is one of extreme pride. These people have been resourceful and very independent for all of their lives, and we need to continue to support that independence, I think.

These people are on low, fixed incomes, and this causes them to have a tremendous fear of accessing the health care system. We do not offer, many times, maintenance health care provisions in our insurance payments. So people come in for routine care, and unless a diagnosis can be pinned to the insurance form, it comes out of their pockets many times.

This fear of indebtedness, I think, and their unwillingness to lose their independence from this indebtedness, they do not come in for health care. Many times, they have waited until they are almost so ill that either they have no choice and cannot continue to deny their problems, or someone else accesses the system for them. It is too much of a shame to wait that long.

People in the rural areas do not even have some of the common everyday conveniences that those of us who are able to get around enjoy. For instances, transportation for groceries, or to their doctor's appointment, or to get their prescription filled, they must rely on other people for this. Rural areas do not have mass transit systems. So there are programs, I know, in Aroostook County where homemaker services will provide transportation.

Just on Friday I had a patient who was telling me she was losing her job because of no funding. This person not only provides transportation but home care type things, cleaning, meal preparation, a great thing to keep the elderly person in their home and more independent, but it is in jeopardy because of no funds.

Weather conditions in northern Maine. I met a lady on Sunday who moved from Alaska, and when they were deciding where to move, they tried to choose a place similar to Alaska. I think they found it.

But this is a real problem for the elderly in northern Maine and other areas where the weather is so inclement at times.

Solutions to these problems, as I see it. There are programs called congregate housing and senior citizens low-income housing. I think this needs to continue to have support. I think we need to expand our elderly low-cost drug programs, our winterization programs, our outreach programs, where people go to the home and help these elderly people know what is available for services in their area and help them with forms to get them accessible to these services.

I think we need to continue the homemaker's service and home health care services. Many times we release our elderly patients from the hospital only to leave them astray and not have any follow up in the home. But we need the nurses and the other health care professionals to go to the home. I think in the long run it prevents the readmission, the frequent readmissions because of lack of attention in the home.

I think the programs like lifeline and adult day care centers help families who really want to take care of their elderly loved ones, but because they are forced to have two income households to make ends meet for themselves, they cannot afford to give up one of those incomes to stay, 24 hours a day, taking care of their loved one. But if we had a place like an adult day care center where the adult could be brought there, have good care, good meals, attention, social activities, be stimulated both mentally and physically, and then picked up at the end of the day, then the families could remain independent.

Again, I think with mental well-being, as well as physical well-being, we will see a lot less admissions to hospitals and the high cost of health care that that represents.

Even little things, like eyeglasses, hearing aids, and dental care, are so important to these people. If they can't enjoy television or read the newspaper or hear what their friends have to say they're very much isolated from what we have to offer them in this world today.

Self-esteem and independence are the major factors and I would like to see more emphasis placed on preventive medicine.

I think as far as physician recruitment and retainment, as Dr. O'Keefe has mentioned already, a lot of physicians have these attitudes that they cannot work in rural areas, that they are going to be available too many hours, there is not going to be any backup, the pay is low, the working hours are long, they will not have a family life, the school systems are terrible, the housing is terrible. I think a lot of that rings some truth, but a lot of it is not true at all.

People are resourceful in these areas. You become a member of the community. The love and the respect and the position that you hold is tremendous. The community spirit is what drew me back to the Ashland area. The kind of love and warmth—when we drove into town on the first day, there was a sign that said, "Welcome Back, Dr. and Mrs. Pelli and Family." Even the moving van drivers could not believe it. There was just a tremendous warm welcome, and this is what I am sure Dr. O'Keefe also experiences in his environment. This is the message we want to get out to those physicians and medical students who might consider rural health care. They ought to get out and do it. The rewards are tremendous.

Most physicians, however, come out of school with at least $50,000 or more of debt. That does not include the interest on that amount that begins many times the day they borrow it. So they already have a few years of interest accruing on that amount.

The physician does experience lower income and there are longer hours. But, I think the Government can help in this regard. Maybe—as Dr. O'Keefe has alluded to—tax incentives for the physicians in rural areas; also, considering favorable reimbursement for Medicare and Medicaid to physicians in rural areas, maybe allowing them 150 percent of the reimbursement versus 75 percent to physicians in urban areas; continue the National Health Service Corps loan repayment program which would encourage physicians to make a choice to go to the rural area knowing that there is this loan repayment program that can help them out.

I think, also, we cannot lose sight of the physician's assistants. I know in the area that I am in, I do have a physician's assistant. Maybe because I was one, I am partial toward the program. But I think this is an individual that can really help a physician extend his or her abilities to all the patients that need health care. It is a tiring job, but with an assistant, it can be managed. I think we should do things to help them. Part of that National Health Service Corps loan repayment program maybe ought to be applied to physician's assistants and their heightened expenses to get their education.

All in all, I think preventive medicine is the way to go. We need to encourage that. We need to encourage patient education to think about that. I use an analogy that we get our cars inspected once a year. We do not wait for the rocker arms to start clacking and the push rods to go through the engine block. But many patients wait until they have symptoms, and many rural patients have the attitude, "If it ain't broke, don't fix it." I think that is part of the whole educational process that we as physicians and health care providers have to provide for our patients.

I thank you again for the opportunity to voice these concerns, and I am looking forward to see what the Government and Congress does for us and for our elderly. Thank you very much.

[The prepared statement of Dr. Pelli follows:]

Aroostook Valley Health Center, Inc.
P.O. BOX 127 ASHLAND, MAINE 04732 TEL. (207) 435-6341

September 18, 1989

Hearing - House Select Committee on Aging
Subcommittee on Human Services and
Senate Special Committee on Aging
Senator William Cohen
Congresswomen Olympia Snowe
Bangor House
Bangor, ME 04401

As a physician in a rural area of Maine I would like to take this opportunity to express some of my concerns dealing with our elderly and their access to health care. I will be discussing the issues based on four areas of concern. The first will be pre-hospital care, the second hospital care, the third post-hospital care and the fourth physician recruitment and retainment.

Issues dealing with pre-hospital care include a very major theme: pride of our elderly. There is very high unemployment and many people on low incomes. Our elderly are not only on low incomes but these incomes are fixed incomes. They have a real fear concerning the cost of medical care and have to think twice before accessing health care due to their fear of indebtedness. These people are generally less sophisticated and are unaware of some of the few services that might be available to them. The elderly are at risk for chronic diseases and are more than likely to require several medications. These medications are very expensive and represent a large percentage of their net income each month. Their mobility is also a major obsticle in their lives. Routine tasks such as groccery shoping, obtaining their medications or keeping their doctor's appointment become major tasks especially in rural areas where there is no mass transit service. The weather may be a major factor potentially causing them harm. In northern Maine, winter is a long season. This requires major expense for home heating costs which also represents a major percentage of their fixed incomes.

I would encourage this committee to consider supporting several programs such as the congregrate housing project, expanding the guidelines for the elderly low cost drug program, winterization programs, outreach programs, homemaker services, home health care services, lifeline program, adult day-care programs, and assist those in need for eye glasses, hearing aids and dental care. All of these services would assist the elderly in maintaining their independance, maintain their self-esteem and remain in their own homes as long as possible. This would contribute to a more "preventive medicine" approach to their health care both mental and physical and, in the long run, keep the cost of managing acute care problems to a minimum. These programs would also give that added support to families who feel committed to caring for their elderly family member but know that they need two incomes today to maintain their own home and could not afford to give up one of their incomes to allow a fulltime care-giver at home. The improved attitude of the families and the elderly person would favorably contribute to the "health" of not only the elderly person but to the entire family.

Another issue deals with routine health care. Preventive medicine should be our main emphysis for our patients in general. This is very important for the elderly. Our task as physicians is to teach our patients about preserving their health for as long as possible. This means regular physicals monitoring specific conditions such as blood pressure, vision, hearing, weight, cholesterol, thyroid, breast, cervical, and GI malignancy and teaching about smoking cessation, drug and substance abuse, depression, and other safety measures such as use of seatbelts. In other words, to help them maintain as good a health status as possible into their senior years. This means insurances should provide for these screening examinations including mammography, EKG, blood screening, and routine physical examinations. There should be a set of guidelines indicating at what age and how often these tests should be done and that if ordered with this prescribed frequency, the insurances will pay for this preventive care. All other times will then not be covered by the third party payers. If we can prevent illness and disease or discover them before the patient becomes symptomatic with a particular malady, their treatment and "cure" will be far less expensive and resource consuming. (I have included a sample schedule as an example.)

Next is the hospital setting. It seems that those elderly patients who delay access to health care for acute problems for what ever reason require longer hospital stays and exceed their DRG reimbursement. This is a major problem for our hospitals in rural areas who are striving to be cost conscious. At The Aroostook Medical Center (TAMC) in Presque Isle, ME their bad debt is very low - 3%. People here have a strong sense of obligation to pay their bills. Because of this and their fear of indebtedness, they delay access to health care until they can no longer deny that something is wrong or until someone else intervenes for them. The payment to rural hospitals should and needs to take this into consideration. These hospitals should not be classified on "number of beds" but by their location or distance from an urban area. A 100 bed hospital in rural America, several hundred miles from an urban area is just as rural as the 35 bed hospital in a rural American community. This is true especially when a hospital like TAMC is realy three small hospitals separated by about 12 miles and in three different communities. All of these hospitals are 150 miles from the closest tertiary care hospital. We have several patients awaiting nursing home placement in the hospital on any given day. There is a shortage of nursing home beds in the County. Nursing home placement patients who are in these acute care beds are at risk for developing hospital aquired illness, lack the stimulation and orientation afforded them in a nursing home environment and generally do not do well both mentally and physically.

Thirdly is the post-hospital setting where the elderly patient is sent home to care for themselves. Expansion of the home health care service and the homemakers service would allow these elderly a smoother transition from hospital to home care and would contribute to their mental well-being which has a great deal of impact on their physical wellness and recouperation. The homemaker service also would provide transportation for these elderly to their doctor's appointment and help them with obtaining their prescriptions and grocceries. We need services in the area of patient education especially for diabetics who need meal plan training and follow-up. This would establish more independance for the patients and less chance for problems requiring readmission to an acute care hospital.

Fourth, physician recruitment and retainment. Physicians today finish their training with $50,000.00 or more of indebtedness. This does not include the interest on that money that may have been acruing for several years. This with the fact that incomes for physicians in rural areas are less than for urban physicians would be one of the discouraging factors causing them to avoid rural medical practices. The competition between urban vs. rural practice over salaries, educational opportunity for the physician and his/her family, housing, social and cultural stimulation and recreation and family time is very onesided in favor of urban areas. Programs that reward physicians in rural areas may help the maldistribution of our physician work force. Programs such as a tax incentive for rural physicians, favorable reimbursement from third party payers including Medicare and Medicaid - ie. 150% of cost to the rural physician verses 75% of cost to the urban physician, continuation of the NHSC loan repayment program and expanding this program to include more areas of the country and support for the Physician Assistant programs to allow for more physician assistants to be able to fill the job opportunities in these rural areas.

These are the areas of great importance to me as a rural Osteopathic Physician whose desire is to practice preventive medicine for my patients and live and grow old in a community that both nourishes us and accepts us as members.

Respectively Submitted by:

Roger T. Pelli, D.O.

Roger T. Pelli, D.O.

Comprehensive Periodic Health Evaluation

Age	16-20	20-40	40-50	50-65	65+
Data Base(1)	once	review	review	annual	annual
Physical(2) Examination	once(3)	once(3)	annual	annual	annual
Vital signs(4)	yes	yes	yes	yes	yes
Cancer check-up(5)	once	once	annual	annual	annual
Breast Examination	instruct in self-exam	review self-exam	annual exam	annual exam	annual exam
Vision Test(6)	once	once	once	annual	annual
Bloodwork					
Hb/Hct(7)	once	–	–	–	–
CBC w/ diff	no	once	q 5yr	q 2 yr	annual
Chemistry(SMA)	no	once	q 5yr	q 2 yr	annual
Electrolytes(8)	no	once	q 5yr	q 2 yr	annual
Lipid Profile(9)	once	once	q 5yr	q 2 yr	annual
Rubella titer(10)	once	prn	prn	–	–
STS(11)	prn	prn	prn	prn	prn
Urinalysis Dipstick/micro	q 3yr	q 3yr	q 5yr	q 2 yr	annual
Pap test(12)	annual	annual	annual	annual	annual
GC culture(13)	prn	prn	prn	prn	prn
Wet mount(14)	prn	prn	prn	prn	prn
Stool Guaiac for Occult Blood	–	–	–	annual	annual
Bowel Function Evaluation(15)				assess and advise	
TB Test(16)	PPD once	PPD once	PPD once	PPD once	PPD once
Tonometry(17)	once	once	q 2yr	annual	annual
Audiometry(18)	once	once	once	q 2yr	annual
EKG(19)	no	once (baseline)	once	annual	annual
PFT(20)	no	once (baseline)	once	q 2 yr	q 2 yr

Age	16-20	20-40	40-50	50-65	65+
Sigmoidoscopy or Colonoscopy(21)	-	-	-	every 3 to 5 yr after two negative exams one year apart	
Prostate Ultrasound					
Endometrial tissue sample (22)			at menopause in high risk women		
Direct Laryngoscopy(23)		-	annual	annual	annual
Chest Xray(24)	-	-	-	q 2-5yr	q 2-5yr
Mammography(25)	no	baseline	individualize	annual	annual
Barium Enema	-	-	-	once	q 3-5 yr
Immunizations					
Td Toxoid or (26) Tetanus toxoid	q 10 yr	q 10 yr	q 10 yr	q 10 yr	q 10yr
Hepatiis B(27) vaccine	..........................as indicated				
Pneumococcal(28) vaccine-23	..........................as indicated				yes
Influenza(29) vaccine	..........................as indicated				yes
Seat Belt Use	.... assess use and educate..................				
Nutritional Assessment (30)	......assess and educate................				
History of sexual functioning	yes	yes	yes	yes	yes
Stress level evaluation (31)	..........assess and advise...........				
Substance and Alcohol Use Evaluation	..................assess and advise.............				
Tobacco Use Evaluation	.............assess and advise..............				
Exercise level evaluation	...........assess and advise..............				
Home environment evaluation (32)	....assess and advise............				
occupational Hx.					

prepared by Charles R. Perakis, D.O. 10/19/85

RBD, D.O. 9/4/89

Qualifying Statements on the Comprehensive Periodic Health Evaluation

(1) The Data Base includes the review of systems, past illnesses, past surgeries, medications, allergies, family history, and habits

(2) The physical examination includes the examination of the breast, testicles, rectum, and pelvis

(3) Some persons may need more frequent physical examinations i.e. women using oral conraceptives and school bus drivers

(4) Record the pulse rate, blood pressure and weight with each visit; record the height with the first visit; record the temperature and respiratory rate as indicated.

(5) Includes examinations for cancers of the thyroid, testicles, prostate, ovaries, lymph nodes, oral region, and skin. Remind patients of the warning signs of cancer and the risk of excessive exposure to the sun.

(6) Determine visual acuity with and without glasses or contac lenses; check color vision and depth perception at the time of the first physical examination.

(7) Do this test if other bloodwork is not done. Important for menstruating women and those who have previously been anemic.

(8) Every six months check the potassium level of patients who are taking diuretics.

(9) Check patients with a family history of hyperlipidemia or heart disease more frequently.

(10) Immunize susceptible persons, especially nonpregnant women of childbearing age. Women should be counseled to avoid pregnancy for three months afterward.

(11) Check for syphilis in those with other sexually transmitted diseases, those with multiple sexual partners, and women at the beginning of their pregnancies.

(12) The American Cancer Society recommends patients have Pap tests performed at least every three years after two negative tests one year apart. The test is recommended for women age 20 to 65 and those under age 20 who are sexually active.

(13) Check for gonorrhea in those with other sexually transmitted diseases, those with multiple sexual partners, and women at the beginning of their pregnancies.

(14) Check those with other sexually transmitted diseases, those with multiple sexual partners, women at the beginning of their pregnancies, and those with symptoms of vaginal itching or unusual vaginal discharge.

(15) Recommend sufficient fiber in diet; evaluate any changes in bowel habits; advise of the need for examination of stools.

(16) Perform if desired or indicated by history.

(17) Caution patients regarding the need for regular checks of intraocular pressure. Determine if this has been checked by an optometrist.

(18) Perform more frequently in patients who work in noisy environments.

(19) Patients with hypertension, heart disease, or other indications may need more frequent studies

(20) Offer to those who smoke, have a history of respiratory disease, or exposure to air pollutants.

(21) Patients can choose sigmoidscopy, left colonoscopy, or total colonoscopy depending upon individual considerations.

(22) High risk women include those with a history of infertility, obesity, failure to ovulate, abnormal uterine bleeding, or estrogen therapy. Recommended every one or two years.

(23) Offer to patients with a history of excessive exposure to tobacco and/or alcohol.

(24) Recommended for high risk patients--those who smoke, those with a history of exposure to known or suspected carcinogens, and those with a history of respiratory disease such as asthma, bronchitis, or emphysema.

(25) More frequent examinations are recommended in patients who have a family history of breast cancer in their mothers, sisters, grandmothers, or aunts.

(26) Tetanus toxoid should be given to patients with bites, punctures or other dirty wounds if they have not received a booster within five years. Determine if the patient has had the primary series. The primary series consists of three injections of the preparation for adult use, with the second at four to eight weeks and the third at six to twelve months.

(27) Recommended for health care workers in frequent contact with blood or blood products; renal dialysis patients and staff; institutionalized patients and staff; hemophiliacs and other patients receiving frequent transfusions; male homosexuals; prostitutes, sexual partners of surface antigen carriers; drug addicts; travelers to endemic areas.

Three deep intramuscular injections, the second at one month and the third at six months.

(28) Recommended for patients with chronic illnesses such as sickle cell anemia; multiple myeloma; cirrhosis; kidney failure; or asplenia (anatomic or functional); transplant recipients; the elderly; conditions that predispose to serious pneumococcal illness including alcoholism, congestive heart failure, and immunosuppressive disorders.

One intramuscular or subcutaneous injection; no repetition is recommended at present.

(29) Recommended for patients over 65; patients of any age with heart disease, chronic lung or kidney disease, diabetes or other metabolic diseases, severe chronic anemia, or immunological disorders (including some malignancies). One injection.

(30) Inform patients of general recommendations; increased fiber decreased sugar, sodium, and animal fats; moderate if any use of alcohol; maintanence of ideal body weight

(31) The Holmes Social Readjustment Rating Scale rates life events frome 0 to 100. i.e. Trouble with boss-23; death of a spouse-100.

(32) Determine who lives where the patient lives; assess family dynamics; recommend smoke detectors; recommend safe storage of firearms

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September 18, 1989

Testimony- House Select Committee on Aging
Subcommittee on Human Services and
Senate Special Committee on Aging
Senator William Cohen
Congresswomen Olympia Snowe
Bangor House
Bangor, ME 04401

I would like to add two points to my original written testimony. The first deals with obtaining tests on Medicare patients without an office visit. I have a 75 year old patients who is illiterate and who has adult onset diabetes mellitus. I have been obtaining fasting and 4pm blood sugars on him to monitor his response to oral hypoglycemics as an outpatient. He is unable to learn to use a home blood glucose monitoring device. I have been informed by my staff that Medicare will not pay for a test ordered without an office visit. This means that now I have to see him every time he comes in for his blood sugar test and charge an office visit fee besides the blood sugar lab fee. I feel that this is absurd.

The second point is that one way to offset the high cost of tuition experienced by our medical students, both D.O. and M.D., is to have our federal government subsidize medical schools. I feel that this should be done in a very judicious manner so as to select out those schools whose missions are to train and encourage Family Practice physicians. Also, to develop more favorable reimbursement to those D.O. and M.D. teaching hospitals who demonstrate a commitment to Family Practice teaching programs at the residency level to continue to encourage these residency programs. I suggest that this federal support come with the mandate that the residents then have an obligated rural practice service responsibility in a health manpower shortage area within that state.

I am sorry that these comments were not part of my original written testimony. I appreciate being able to have these added to my original document and thank you for the opportunity to testify at this very important hearing for Maine's elderly and for the elderly throughout this country. Thank you both for your sincere interest in these issues.

Respectfully submitted by:

Roger T. Pelli, D.O.

Roger T. Pelli, D.O.

Senator **Cohen**. Vera Johnson.

STATEMENT OF VERA JOHNSON, VINALHAVEN, ME

Mrs. **Johnson**. Well, I have a terrible voice. These men all have a good voice. I asked Dr. O'Keefe—he has always done everything for me—to give me a new voice and he said he couldn't.

I live on Vinalhaven, which is a small island. We have about 1,100 people yearly, but if it wasn't made of granite, I'm sure in the summer it would sink, because we have from 7,000 to 8,000. You should see it then.

Well, I'm supposed to talk about health. You know, I'll talk forever if you'll let me. But you do like they do in Family Feud. He waves his hand and everybody stops talking. So, when you want me to stop, you do the same.

I went to Vinalhaven when I was 6 years old, and they say never correct a VIP in public, or a child in school. Take them to one side.

But I went in 1902, so that only made me 6 or 7 years old, because I was born in 1895. You can subtract it yourself.

One could never find a place so much full of love as Vinalhaven. Because I have been fortunate to have a son and daughter who love me dearly, take care of me.

I will step to one side and say something about my son. He now lives in Maryland and Florida. He came 4 years ago to visit and stayed the summer with me, and he was taken with a massive heart attack. Dr. O'Keefe, he worked on him from the minute he got there until he got him to Rockland, and all the doctors there—Do you know Dr. Lawrence or any of those?—they will tell you that Dr. O'Keefe saved his life while he was here from that time until October. He is still going from doctor to doctor, but that is how much Dr. O'Keefe does. That is one of the things Dr. O'Keefe does for him.

But I'm going back a ways, way back in Vinalhaven history. We were a very flourishing town, a granite town, and we had six doctors. Then business went down, down, down, and the doctors went down, down, down, and we had one elderly one.

Then we had a young doctor come there, Dr. Shields—a lot of people liked him; a lot of people didn't like him—until my husband's father and a number of men on the street had met Dr. Earl and thought he was going to be a fine doctor providing—because he had come here ever since he was young.

So they got money and hired him to come there—to make up the money for us, and that is who Dr. O'Keefe met and thought so much of, and that is why we have got Dr. O'Keefe at Vinalhaven.

I would like to say so much. I wish I knew how to say it all. But Dr. O'Keefe takes care of the mothers who are going to have babies, brings that baby into the world. He takes all ages—from no age at all to me, who is 94 years old.

So, you see the difference that these—the different breaks, the different this, and the different that that he has to tend to.

I've had several breaks, and I've had several little spasms with my heart, and it has always been in the night, in the middle of the night that I've had to call him, 1 o'clock, 2 o'clock, or else he's been out with the Boy Scouts in the woods, and he has always come instantly. I've never called him—he always has plenty of time for me.

I shouldn't talk so much about myself, but in a minute I'm going to talk about Dr. O'Keefe. He just is so wonderful. We are so fortunate in Vinalhaven as every doctor at Penn Bay will tell you.

But now I want to go back, if I may, and talk about advice for older people. I grew up in Vinalhaven. I've had a wonderful, wonderful life, so full of love.

I've got to have a drink of water. You know, E. Keith Elliott, when he went to speak, he always had to have three glasses of water: one first, then one in the middle of the speech, and then one on the last. Of course, I'm not E. Keith Elliott, but I'll have a drink of water.

To grow old is terrible, I think. I was wonderful when I was in my eighties, flipping flopping here and there, spending every cent that I had. But the time comes when you have to admit that life isn't what it was. I have never felt old. I've always been young, even if my limbs weren't. So, it is really pitiful, these older people that don't have people to love them and take care of them.

I have a nice home, but I had run out of money. But my daughter lives upstairs and she takes care—I have safety in that way; I live downstairs.

Well, I had broke my right shoulder and I had broke my left shoulder, and then I went back a couple of years ago and broke my left shoulder again, which left me a cripple really. For a year I wasn't any good at all, but then one day my mind said to me, "Get up, Vera, and get going." So, I decided I was going to live again.

Dr. O'Keefe was so wonderful through all of that. In this, we have a wonderful doctor.

I can't get my breath. I talk too fast.

Then there come a time when I did the second with the left shoulder, the second time. My daughter was no longer able to physically take care of me. She lives upstairs and I live downstairs in a nice home. But I have no money to do those things with nowadays.

So, there was a next door neighbor to us, was a woman who was 100 years old, and she had this woman that came in and took care of her, morning and night. So, my doctor contacted them—I can't remember what they are—area In-Home Agency or some such thing as that, and she came over to see me.

It is hard when you have been independent all your life. I never had to have anybody help me. I've always been able to pay my way.

So, I just warmed to it first, and they said, "Well, you know, Dottie cannot take care of you at night." I was crippled. I was like a baby. I had to be washed and dressed and fed and the housework done and everything—everything just done.

So, there is this lovely woman who used to come in once a week and clean my house up for me and she was there, and she said, "I'll take care of Vera." This woman—Elizabeth Tibbetts is her name—is who I'm talking about.

So, she stayed to take care of me, because I'm very, very fortunate in essence—Dr. O'Keefe will tell you—some people aren't so fortunate, because she doesn't charge so awful much, and a lot of people in town had just enough money so they can't get help, but they would like to have some help like that.

But we don't have enough people that they would take care of you. This is a small area, remember. We are way off from everything else.

But they do wonderful for me. I praise them. This Elizabeth Tibbetts comes over once a month to see me. Dr. O'Keefe comes down to see me.

Are you going to wave your hand? Is it time for me to stop?

Senator COHEN. We're getting close.

Mrs. JOHNSON. Do you want me to close?

Senator COHEN. In about 1 minute.

Mrs. JOHNSON. What was I going to say next? I want to say something.

We're a small place—talking about doctors coming to small places, it is awfully hard for these young doctors when they look at other doctors making so much money. It is like asking ministers. We have a terrible time of getting ministers—going from politics to ministers.

Senator COHEN. We've got to stick with the doctors today.

Mrs. JOHNSON. We don't pay so much money, and if we get a good minister that wants to come here, his wife sees that long line of cars that is going to go on the ferry—this one broke my heart, because I was on the committee—and she was going to come.

But when she saw that long line at the ferry, she wasn't going to live in a place that she had to wait to get off the island. So we lost him.

I think that is the way with the young doctors. It is hard for them to go into these back places, not for them, but for the wife, if it had been the wife that had been wanting to come. It must be awful hard. I thought of Dr. O'Keefe with his beautiful wife—and they live way up in the woods—coming over there. She knew nobody. She was a different class, really. It must be terrible, and it must be hard in their life, their married life, to make things smooth for them.

I think they've got to do something about helping out young doctors to go in this place, give the women a lot of inducements.

I don't know what else to say.

They are not going to say this—I've got half a second left—as I said, Dr. O'Keefe has to take care of us from birth or before birth until death do us part.

I don't know that if any of that was important, but I just wanted to say this, I do think there should be more help for the young doctors and for older people. It is hard to lose your independence. I always was able to take care of myself. I had a wonderful 14 years at Westbrook Junior College where young girls—I guess it is not a college now, not a junior college.

What else could I say?

Senator COHEN. Did you do a lot of socializing at Bowdoin College when you were at Westbrook?

Mrs. JOHNSON. I chased the young men from Bowdoin out of the house with a broom. They were the bane of my life. But I've met three since—I met one 2 years ago who said, "Are you Vera Johnson, Mrs. Johnson that was housekeeper at Proctor Hall?" I said, "I sure was." He turned around, back to me, and said, "Get your broom, because I was the boy that pulled that bell."

Senator COHEN. Thank you very much, Vera.

We're going to turn now to Roy Gallagher. Perhaps, Roy, you can tell us some of your experiences living in the county.

STATEMENT OF ROY GALLAGHER, EAST MACHIAS, ME

Mr. GALLAGHER. Thank you, Senator Cohen and Representative Snowe. I want to tell you a little bit about my health experience.

As Senator Cohen said, I'm 78 years old. I live alone. I'm a widower. My wife passed away 6 years ago.

About 16 months ago I was diagnosed as having prostate cancer. After 6 or 7 days of minor surgery, the doctor came in and told me what my problem was and that he would line up treatments for me at the cancer center in Bangor.

Now, I returned to East Machias from the Ellsworth Hospital where I had my minor surgery, and a few days later I had to go back down for a CAT scan. A few days later I had to return again for a series of blood tests, x-rays, and so forth and so forth.

Eventually, I got to the cancer center in Eastern Maine Medical Center here in Bangor, and I was informed by the endocrinologist that I would receive anywhere from 35 to 50 radiation treatments. These would be daily, Monday through Friday.

I was advised that there was a McDonald House where I could live at a fraction of what it would cost me in other places nearby, near the hospital.

I am very fortunate in being the owner of a motor home, so with the aid of my nephew, I moved my motor home up to an RV center near Bangor. He brought my car up, and I set up housekeeping in the RV center.

Monday through Fridays I come to town and had my radiation treatments. On weekends I traveled back to East Machias, to do my laundry, and take care of current chores.

I have an acquaintance in East Machias that experienced the same thing as I did, but when it came to the treatments, his wife wasn't in the best of health, and his concern for her health was such that he thought the only way he could do it would be to return home every day.

Now, anybody who has had radiation treatments will tell you that it saps the strength, the energy, right out of you. It was a killing experience for him, and it is my guess, due to that traveling back and forth, he hasn't fared as well as I have with his treatments. Whether anything can be done regarding that, I don't know.

But the elderly of today—people of my age, people of Mrs. Johnson's age—we were born and brought up at a time when there were none of these agencies in existence. We became much more independent. We looked for nobody but ourselves to take care of ourselves. We feel that we are imposing when we do look to any agency.

I, myself, I have no complaints as far as the personnel at Eastern Maine. They were wonderful to me. People from the different agencies came inquiring about my well-being.

I have medical insurance. I get reports every now and then from Medicare about the expenses. But I had no worries. Everybody doesn't have that.

One of these two doctors has mentioned weather. I was fortunate; mine was in the late summer and fall when I had to do my traveling. In mid-winter, I would panic, and I'm sure they must.

Above all, I think the fact that in Maine, especially in my experience in Washington County, we are so proud and independent that we don't want to entangle anybody else in our affairs. We want to do it on our own.

Years ago, if I took sick, I called the doctor. He came to the house. I doubt very much if I could find a doctor today.

Mrs. JOHNSON. Dr. O'Keefe does.

Mr. GALLAGHER. I'm talking Washington County.

A lot of people, their health actually deteriorates in Washington County or in the rural areas, not so much that the doctor isn't available, but they hesitate to call on him because they have to depend on somebody else to get them to the doctor and get them back, so forth and so on.

I hope that my few words have been constructive. Thank you very kindly.

Senator COHEN. They have indeed, Roy, and thank you very much.

Just a couple of questions to our panelists.

Dr. O'Keefe, Vera Johnson is perhaps a classic example of the type of person who lives in Vinalhaven. I know on my trip there when I went to celebrate the Fourth of July, I saw people in their eighties and nineties, and I said to one of my aides, "What is it on this island?"

What are they drinking or breathing that allows them to live as vigorous a life as you still lead even today at the age of 94? I would suppose everyone in this room would wish to be as alert and alive at the age of 94 as you are. But it is typical of that particular island, I noticed in the people that I met there.

Dr. O'Keefe the same must be true of someone like yourself. You have a young family that you are raising there. You must have the same basic kind of spirit that brings you to Vinalhaven as the people who have settled there originally. How many do you think are out there like yourself or Dr. Pelli?

The most difficult thing is to attract doctors there. You suggested, well, that we have tax incentives, or that we forgive student loans. Is that going to be enough, just the mere exposure, and the obligatory service for 1 or 2 or 3 years, to cause doctors to want to settle in those areas?

Dr. O'KEEFE. Well, I think what Vera mentioned about the love of the community is very important. That is the reason that Dr. Pelli is in Ashland; that is the reason that I am in Vinalhaven. You cannot put a dollar figure on that.

I think that doctors do not know the love that they can receive and the benefits that they can accrue from being a physician in those areas. That is why I feel that sometimes to get that lesson one has to be forced to have the lesson. I think that inside every budding medical student who thinks they want to practice in suburban Connecticut—myself included—there must be somebody inside who wants to practice in a rural area.

I believe a great sculptor said, inside every piece of marble there is a statue waiting to be sculpted, I think that inside every physician there is a rural physician waiting there to serve, but conventional wisdom may be keeping him away from breaking out of the marble.

Senator COHEN. Does that potential rural physician also have a rural oriented wife who is willing to make those kind of sacrifices? Isn't that also a problem, that you have a wife who says, "Wait a minute—Dr. O'Keefe is idealistic and dedicated to serving rural people—but I kind of like being in an urban area."

Dr. O'KEEFE. I think a quote that I heard a few times was, "How come we don't have any Bloomingdales nearby?" This is a real problem for wives. Roger Pelli mentioned that wives become unhappy in rural areas. There is no easy solution to that, but I think that eventually after a few years, perhaps after you buy a house, you start buying a practice, you sink a few roots, you have a child, you get into the schools, and suddenly you say, "Things aren't so bad. I can live without Bloomingdales," and you do, and you thrive without Bloomingdales. You can always go to New York to get that.

Senator COHEN. Dr. Pelli, earlier you mentioned something that caught my attention. You mentioned preventive medicine, and that we take our cars in for inspection once a year, sometimes twice a year. However, we do not take ourselves in for inspection, but if we did that with people, we might reduce the kind of problems that eventually demand much more acute attention.

I introduced a bill—I must tell the audience—back in 1978. It was the Annual Physical Examination Act of 1978, I think I called it. I have never received more negative mail—other than during Watergate—in my life, and I got it from everybody.

What I tried to do is to create tax incentives to people to go and have an annual physical examination with the idea that if you went for the annual physical checkup, the doctor would examine, perhaps detect something in the early stages, and save a good deal of heartache later on.

Well, the doctors came in and attacked me saying, there is no list that one can check on an annual basis that will be satisfactory. You cannot do that, and therefore we are opposed to it. The taxpayer said, that is a bailout for all the doctors. All you are trying to do is put more money in the doctor's pockets by making us go to the doctor every year. So the whole project died a very ignominious death. That was one way I tried to encourage people to engage in more preventive medicine, that coupled with "wellness"—an emphasis on wellness programs.

I tried also to create tax incentives for employers to have wellness programs for their employees so that they would start taking better care of themselves. Employees would eat better, exercise more, stop smoking, reduce drinking. Of course, that did not go very far either, for a variety of reasons.

But it seems to me that preventive medicine has to be a component—a very important component—of health care in the future.

Dr. PELLI. In what I have handed to your aides in a printed fashion was some suggestions dealing with that. I do not think everyone from birth on needs an annual physical, but certainly as they get into the senior years, the frequency with which chronic diseases take their toll are obviously higher. So I think we need to concentrate on that age group for the type of annual review or examination.

There, I believe, will be very soon a study out that was a cooperative effort, I am sure, from many, many disciplines to come up with some routine guidelines as to when you do mammography, how often do you do sigmoidoscopy, et cetera. I think those guidelines need to be looked at a national level.

I think we have to have some uniformity with how we approach our patients, especially our senior citizens. I think we cannot forget them and forget the fact that these are the people who are going to get these chronic diseases and ought to have the routine mammogram, but insurances do not pay for it now. Unless you find a lump or find a reason, a routine mammogram is not covered. Yet, the people who get the most breast cancers, or any kind of cancer, are going to be in the senior citizen age group.

Again, if we wait for the cancer to rear its ugly head in the way of symptoms in these patients, many times it is already too late. The cancer has masticized, and then where is the cost for chemotherapy, hospitalization, and then dependent care?

So I think preventive medicine is the way to go, and maybe an alteration of that bill to be more one-sided toward the senior citizen that needs the care and now does not access it because it is not going to be paid for by insurance.

Senator COHEN. Just one more question and I will yield to Olympia. You mentioned you had experience as a physician's assistant and now as a physician. Could you describe the difference in attitude toward you within the community now compared with the attitude when you were a physician's assistant. I have heard, for example, or read that not that the physician's assistant "can't get no respect," but that people tend to place a much higher premium upon a physician as opposed to a physician's assistant when seeking out health care.

What has been your experience—I know it has been limited, since you have only recently returned to Ashland—but what was the attitude of the people who came to you while you were a physician's assistant versus that now that you are a physician?

Dr. PELLI. I do not think the attitude is changed, and I say that with deep sincerity, because what they saw in me when I was a physician's assistant was a health care provider who cared about them. Now they see me as a health care provider who cares about them.

Now they call me doctor and it is legal. They used to call me Doc as a nickname back then. But I was the same person then as I am now, and they recognize it, and I think that is why they entered into this agreement and that is why I am back. I don't care who you are, physician or physician's assistant, if you don't show caring, you are not going to get that kind of support.

There have been supervising physicians that came to Ashland when I was a PA there—the patients saw me rather than the individual physicians, and I was seeing twice the encounters as the physician. That was not because I was the PA and this individual was the physician. It was because they perceived that I cared and they did not perceive that the physician cared.

So I think it has got to be innate in the person who goes there, whether they are a PA, nurse practitioner, or physician, and not the title. You cannot fool these people. You have to be honest and sincere, and the title really does not mean a lot.

Mrs. JOHNSON. I'm going to butt in here and say I think that is very true, because Dr. O'Keefe has—we had one woman and I went up to her—Dr. O'Keefe would know—and she was terrible. She said I could look at my paper and see what I had. So I walked out. When I went by the desk I said, "I don't want anything more to do with her. I'd rather die than have her," and I went home. Of course, I lived.

But last year we had an adorable young lady, Mrs. Peterson was her name, and I really think she is going to be a good doctor to somebody somewhere.

Representative SNOWE. Thank you. It is interesting to hear from all of you, both from the perspective of the provider as well as the older rural resident. I think that is what has been very interesting about this panel this morning.

I want to get back to preventive services, because I do think they are critical. The irony is, in many of the rural health centers in the medical delivery system, preventive services are provided, and yet many of these services are not reimbursable. Is that not correct?

Dr. PELLI. That is correct.

Representative SNOWE. The real difficulty in all of this, is ensuring that they are reimbursed so that we can prevent more serious disorders in the future. For example—mammograms—we changed that law just over a year ago, I hesitate to mention the bill's name, Catastrophic Legislation, to cover screening—for those over 65. In addition, another Congresswoman and I are going to be introducing legislation to urge States to change their insurance regulations to require that to be incorporated.

But that is only one example. I mean, you get into osteoporosis and other examinations that are not reimbursable or reimbursable in only limited instances. This is one of the difficulties in all of this for many of the elderly.

Getting back to what kind of incentives or inducements we can provide for budding physicians, did the National Health Service Corps help you in any way? It located you in Vinalhaven. Were there any other attractive aspects to that program that might be helpful in the future?

Dr. O'KEEFE. The National Health Service Corps was a godsend for me and for Vinalhaven, because it gave me many years, 8 or 10 years, of a Government supplied salary before I became a private physician. It gave me freedom from the insecurity of having to worry, "would I make it privately?" It gave me freedom from worrying about whether patients ever had the money to pay for their care; either of those worries can ruin the doctor/patient relationship.

So the National Health Service Corps gave me a salary and also forgave some of my medical school debts after I stayed 3 or 4 years. I believe that they took care of 80 percent of those debts.

Representative SNOWE. This program is being restructured to a loan repayment program. But you could, as you were saying, Dr. Pelli, combine various incentives from a tax credit to a loan repayment program, for example, or loan forgiveness. Beyond that, what about medical schools? Cannot medical schools provide programs in this area?

Dr. PELLI. Yes. There is a program called AHEC, and I must plead ignorance as to the exact meaning of what those letters stand for, but I think it is Area Health Education Program—I'm not sure what the "C". . . . This is a program where medical students are sent out to rural areas to work with doctors such as Dr. O'Keefe and myself and witness firsthand what rural health care is all about.

I think with people who are excited about being in the rural areas as supervising physicians, I cannot see but it has to spill over into the excitement to these young people. They are still impressionable. Many of them do not have a lot of ties so that really all they have to do is concentrate on what they are doing, and maybe the budding physician, that rural physician that is buried inside those people, will be activated when they see people such as Dr. O'Keefe and myself excited about what we're doing. It will spill over onto them, and they will get interested in rural health care.

So I think maybe the Federal Government, through the medical schools in this country, can help support such a program.

Representative SNOWE. Do you think it is more attractive in medically underserved areas to have the salary paid by the community or the rural health center or to engage in a private practice?

Dr. PELLI. I think when a physician or any businessman is going to start off in business, you are looking at a certain degree of indebtedness to get started, and the whole wonderment of, "When I open my doors, what is going to happen?" "My creditors are going to want to be paid."

I will never forget the time I walked out of the door and there was a hundred pounds of potatoes on my front porch. That is great, but my creditors will not take the hundred pounds of potatoes.

So there are those concerns, obviously, in starting any business, including a medical practice.

Maybe what the Ashland-area towns, the six communities that helped me, maybe that kind of enthusiasm and gutsiness, if you will, if the message gets out to the right areas, maybe people will have the same kind of courage.

Representative SNOWE. Are there any other similar arrangements that you know of?

Dr. PELLI. No.

Representative SNOWE. Do you think it is possible?

Dr. PELLI. I think it is. I had a father call me from New York City asking me about my program and what I did, because he has a son that is going to start medical school next year. I have had two physicians contact me from different parts of the country.

The message has to get out, and I think we are just scratching the surface. But if people can just get the idea that this is possible and it can work, it might happen in more places of the country.

Representative SNOWE. Roy, I wanted to ask you a question about transportation. Is there any transportation service between Machias and Bangor?

Mr. GALLAGHER. There is a bus, a van, from Calais to Bangor. I'm not really privy to what the schedule is.

Representative SNOWE. So it may not be on a daily basis, or is it?

Mr. GALLAGHER. It is on a daily basis. It is very reasonable, somewhere between $6 and $10. I'm not sure of that. The only reason I know is because when I got through my treatments, I had to take a bus to go back and get my motor home.

Representative SNOWE. Obviously, that is very difficult, especially when you are having radiation treatments.

Was your prostate cancer diagnosed in East Machias?

Mr. GALLAGHER. Oh, no, no. In Ellsworth.

Representative SNOWE. In Ellsworth?

Mr. GALLAGHER. We have a small hospital, as you are aware, in East Machias, and there is another one in Calais. But as these two doctors know—the population is so small, with the economics, it just can't really support them in the manner that the doctors and the patient would like to have them.

In Washington County—I mentioned the CAT scans. I had to go to Ellsworth. There is a mobile unit that I think originates in Bangor and travels to these outlying places. There is none that comes to Washington County.

Representative SNOWE. That is an excellent recommendation right there—to have these mobile units going into areas like that.

Vera, one question. Did you have to have emergency services in Rockland as a result of your injury?

Mrs. JOHNSON. What is that?

Representative SNOWE. Did you need emergency services in Rockland?

Mrs. JOHNSON. Dr. O'Keefe looked after me at home. I broke my shoulder there and I didn't go for therapy. I just did the therapy myself through Dr. O'Keefe. But could I get over there—he was very good to me—it had been broken when I was 70.

I don't know if I'm allowed to, but I would praise that agency——

Representative SNOWE. The Area Agency?

Mrs. JOHNSON. Yes. There's a lot of people on Vinalhaven that really need it, but there is not many people willing to do it. I think they want more money or something than they are willing to pay.

If you people can find some extra money, build us a nursing home in Vinalhaven, because it is terrible for myself.

I lived in my home and I loved it, but if it hadn't been for the nursing agency, I would have had to have gone to a nursing home in Rockland, because my daughter—lovingly and willingly, and my granddaughter and everybody—but they couldn't take care of me 24 hours a day. I mean, they have a life to live too.

So with their care and with my daughter's care and my granddaughter and everybody else in town, I can live there, which means so much, because I really would rather Dr. Earl give me a pill and

I wouldn't speak again than go to a nursing home. They are all right, but I would hate to live in one.

Representative **SNOWE**. Well, thank you all very much for being here today.

Dr. **PELLI**. Thank you.

Senator **COHEN**. Let me thank Drs. Pelli and O'Keefe—who really are an inspiration to all of us—and also Vera Johnson and Roy Gallagher.

I will tell the secret here. Vera Johnson became a Republican because when she was a young girl, some of her friends told her that Republicans were rich and that they had indoor plumbing.

If you only had waited until the Roosevelt era, they probably would have said you could have had a chicken in every pot.

I look at both Roy and Vera, and am reminded of Oscar Wilde who said the tragedy of life is that the body is born young and grows old, and the comedy of life is that the soul is born old, but it grows young. I would say that both Vera Johnson and Roy Gallagher show the wisdom in those words.

Thank you all for coming.

We are going to take a 2- or 3-minute break while we assemble the second panel.

[Whereupon, a short recess was taken.]

Representative **SNOWE**. Next we are going to hear from a panel which will delve into the particular problems that rural hospitals face, and highlight innovative activities that they are undertaking in order to remain financially viable.

The members of this panel are: Ted LaLiberty. Ted is a board member of the Maine Hospital Association; the CEO of the Miles Memorial Hospital in Damariscotta, and the chairman-elect of the American Hospital Association's Section on Small and Rural Hospitals. He offers both a national and State perspective on the problems which impede rural hospitals' ability to provide health care to the elderly individuals in their communities.

Craig Bean. Craig is the CEO of the Houlton Regional Hospital in Aroostook County. The Houlton Regional Hospital has been involved in several efforts which it designed to enhance the hospital's financial picture. These activities include the establishment of a long-term care facility and a cooperative effort between the hospitals in Aroostook County.

Paul Chute. Paul is senior vice president of the Stephens Memorial Hospital in Norway. The Stephens Memorial Hospital has been involved in a number of innovative activities. These efforts are designed to increase the recruitment and retention of staff and to make the facility more cost-efficient.

Ann Morrison. Ann is CEO of the Sebasticook Valley Hospital in Pittsfield. The Sebasticook Valley Hospital has worked to strengthen its outpatient programs, in order to adjust to the changing system of health care delivery.

I want to mention that I am pleased that these three small hospitals are testifying at this hearing today. I personally visited each of them recently, and I am very impressed by the methods which they have used and implemented to adapt to the changing medical environment.

I was very impressed, I have to say, with all of your operations. So I am especially pleased that you are here today to share your views on the survival of rural hospitals and what you are doing to make this possible.

Ted, why don't you begin?

STATEMENT OF CLARENCE "TED" LaLIBERTY, JR., BOARD MEMBER, MAINE HOSPITAL ASSOCIATION; CEO, MILES MEMORIAL HOSPITAL; CHAIRMAN-ELECT, AMERICAN HOSPITAL ASSOCIATION'S SECTION ON SMALL AND RURAL HOSPITALS, DAMARISCOTTA, ME

Mr. LaLiberty. Senator Cohen and Representative Snowe, my name is Ted LaLiberty and I am the chief executive officer of Miles Memorial Hospital. It is a 27-bed acute care hospital and a 41-bed intermediate care facility in Damariscotta. In addition to those services we offer adult day care, we have an education conference center, we have a 47-apartment congregate living facility, we have lifeline, we have a hospice. We have just opened a chemical outpatient dependency program, and we are about to build a skilled nursing facility.

However, I am not here to speak about my facility today. Rather, I am here to talk about some of the issues that we see on a State level and nationally.

I want to thank both of you for turning the spotlight on Maine for today. It is extremely important that rural hospitals and rural health care providers have an opportunity to get their message across, and this is extremely helpful for us. So, thank you both.

Health care in rural America is in serious trouble, as you know. In 1988 alone, 40 rural hospitals closed. In Maine, we have seen the demise of two of our rural hospitals, Castine and Van Buren.

When a rural hospital closes, it not only means a community has lost access to health care, but it also has lost a vitally important element of its infrastructure.

As a State and a Nation, we now have to decide whether diverting Medicare dollars to balance the Federal budget is worth the price when we consider the real impact on our communities of the loss of access to health care and the economic loss that results from the closure of a hospital in a rural community.

One-half of Maine's hospitals are considered rural. These facilities serve close to 40 percent of Maine's population, and that is population which tends to be older and poorer than in more urban parts of the State, and often is in need of more care.

Maine's rural hospitals make up only 25 percent of the State's acute care hospital beds and revenues, which makes them especially vulnerable when State and Federal policies are changed.

This next section sounds like we all have the same writer, but I want to read it because I think it is important.

In 1988, Maine's 20 rural hospitals did have a loss of over $4.2 million, and as you both have pointed out, that was well over $200,000 per rural hospital. Much of these losses can be attributed to the Medicare shortfall, that is, the difference it costs us to treat a Medicare patient and the payment that we receive from the trust fund.

The main cause of the shortfall is the Medicare Program has consistently underfunded rural hospitals with what is known as the urban/rural differential. As you both know, there is some recognition of that issue now in front of Congress.

Rural hospitals have historically been funded less than their urban counterparts while there has been no significant difference in the cost of doing business. In some cases, rural expenses are higher as they have to pay higher wages in order to attract more qualified personnel.

But the differential is not the only problem. The shortfall is further exacerbated by Medicare's traditional funding hospitals with marketbasket updates that are significantly less than the rate of inflation.

The Federal Government must begin to acknowledge that paying hospitals, rural and urban, less than it costs to take care of the elderly citizens will result in further hospital closings and limiting access to care.

In 1989, a first step in the attempt to protect the Medicare Program was taken in the way of a resolution with the American Hospital Association in a grass-roots effort sponsored by the electorate to protect Medicare. I am sure you both are aware of that.

We, along with the AHA, make the following recommendation—when I say we, I mean the Maine Hospital Association as well as the hospitals in Maine regarding Medicare—that payment bear a reasonable relationship to the cost of services used by Medicare patients, by recalculating prices on the basis of cost at least every 4 years, and by updating this by hospital inflation. This should achieve a more realistic pricing structure for Medicare.

We also believe that small hospitals that are experiencing sharp reductions in utilization and operating margins, many of which are in the State of Maine, should be allowed to opt out of the current prospective payment system.

The traditional cost-based reimbursement would be more appropriate to ensure the existence of rural hospitals and access to care for rural citizens. Again, there is legislation proposed to deal with this issue.

Special payment of transitional care—which means rural hospitals that are able to meet not only the acute care needs, but also skilled nursing care—should be provided in order for rural hospitals to serve a more diverse patient population.

One of the ways, as you will hear later, that rural hospitals are changing in order to survive, is the shift of that hospital's emphasis from in-patient to outpatient procedures. This has been a successful strategy for rural hospitals nationally to use. However, it is in danger because of, again, inadequate Medicare payment.

Payment for outpatient services are based on rates charged by freestanding ambulatory or surgical centers. But in rural areas, and for the most part in the State of Maine, freestanding ambulatory or surgical centers do not exist.

It is imperative that Medicare pay hospitals for their reasonable costs in caring for patients in the outpatient section.

The Medicare shortfall is not the only cause of the weakening of rural hospitals. The problems of uncompensated care are a significant issue in this State. Maine's hospitals have the long and proud tradition of treating all patients regardless of their ability to pay, and although this is not included in my notes, I want to underscore that. I know you are aware of this, but I think it bears mentioning that we have not the problem with dumping or not treating all patients equally.

Uncompensated care in the State resulted in Maine's hospitals experiencing a $40 million shortfall last year while caring for those unable to pay.

There are currently 130,000 Mainers who are without health insurance. However, a step was taken here in Maine to help turn that around. The Maine legislature passed an omnibus health care package which contained a program that would provide health insurance to over 21,000 of these underinsured Mainers.

However, a small State like Maine cannot solve the problem alone. We need the Federal Government to begin participating in solutions to cover those citizens without health insurance who are unable to afford it by expanding the Medicaid eligibility and by providing incentives to business to insure their employees. This is not only good for the people who will now have access to health care, but it is also vital for small and rural hospitals who are strapped by unpaid hospital bills.

Covering the uninsured and paying the full cost of care for patients will do no good if the hospitals do not have the personnel to care for the patients. The problems of the recruitment and retention of physicians, nurses, and allied health care personnel is also threatening the rural hospitals' ability to survive in this State. It is not easy to recruit physicians and nurses to the rural part of this State and pay the wages needed to keep them there.

In 1988, rural hospitals had vacancies for registered nurses, physical therapists, respiratory therapists, occupational therapists, and medical technicians that were significantly higher than the State average. Nearly one out of three respiratory therapy and occupational therapy positions in rural hospitals is open, with hospitals unable to fill those vacancies. Hospitals are forced to hire temporary personnel at a much greater cost through agencies. In certain hospitals, the costs of recruitment for physicians and nurses, combined with the costs of using temporary help, are the sole reason for operating losses.

Loss of reimbursement, unreimbursed care, and professional shortages are leading too many rural hospitals to rethink their mission, and in some cases to shut down altogether.

We think Congress can help stem this tide of rural closings. When it was proposed to close rural post offices several years ago, a storm of congressional activity put a stop to those plans. I believe rural hospitals and the health care they provide are equally as important as rural mail, and I know that you do as well.

We would urge Congress to begin fully funding its commitment to hospitals and give us our full markup in the Medicare update; we would urge an end to the rural/urban differential; and we would also strongly recommend that the rural transition grants be greatly expanded to allow rural hospitals that are forced to change their mission to more easily do so; provide us with the funds to help us educate the health care professionals, to staff our hospitals by funding health professional education through scholarships and loans, and providing incentives for health professionals to go to or to return to rural areas.

With your support, we can continue to assure that the residents of Maine, particularly those living in rural areas, continue to receive the best possible health care.

Thank you for your patience in listening to my testimony.

Representative SNOWE. Thank you.

Craig.

STATEMENT OF CRAIG BEAN, CEO, HOULTON REGIONAL HOSPITAL

Mr. BEAN. Thank you for inviting me today.

I am going to skip over the first part of my prepared remarks as much of it has already been addressed by other speakers.

First of all, I will give you a little background on Houlton Regional Hospital. We are an 89-bed acute and long-term care facility. We provide fairly comprehensive services to a population of about 18,000, including an elderly population approaching 3,000. To put this in perspective, the State of Maine is only 13 percent.

We provide many levels of services, full range of acute care, Skilled Nursing Care, adult day care, Meals on Wheels, Seniority Program, Lifeline Program, home physical therapy, cardiac rehab—phases 1, 2 and 3—full range of wellness and educational programs and many others.

Houlton, as mentioned, shares the same fate with other hospitals in the State with its Medicare and Medicaid shortfall. Losses beginning in 1986 were $27,000 and in 1989 we're predicting a $1 million loss out of the $40 million mentioned by Ted LaLiberty.

We need to see continued support by the Federal Government, I think, in meeting the commitments to the rural citizens. Anything Congress can do would be appreciated.

We also have difficulty in getting all professional people that we need.

I was interested in Dr. Pelli's and Dr. O'Keefe's comments this morning, because they started to touch, I thought, on some different approaches. I do not have the answers, but I think we need to talk and come up with more innovative ways that will work so that HRH and other rural hospitals can get people who want to live in rural areas to come to rural areas without major sacrifices to do so.

Dollars are important. I think we have to pay a little bit more for physicians than urban areas, but that is not all we need to do. There are other support systems that need to be looked at. Again, I think innovative approaches are called for.

I certainly would welcome more dialog in this area.

I am mainly here today to talk about a couple of innovative programs in Aroostook County that I think are potential role models for the State of Maine or the Nation and some potential problems at HRH.

First, at HRH we have a skilled nursing facility which Representative Snowe has visited. We were originally an 11-bed unit when we first opened the new regional hospital in 1976, and now have expanded to 26 beds to meet the needs of our service area.

We have experienced problems because half of our patients at any one time are classified as Intermediate Care patients (ICF). They are not Skilled patients (SNF). There are not adequate nursing home beds available in the area to accommodate the Medicaid patients as well as private patients, so this is taking up skilled and acute beds. Not only is placement a problem but I cannot get occupational therapists (OT) or physical therapists (PT) or speech therapists, so I cannot even take SNF referrals from other facilities at this point to give comprehensive rehabilitation services. That ties in to statewide shortages, as mentioned previously.

One of the new concerns that I have is as of September 1, 1989, hospitals are going to be reimbursed by Medicare at ICF or nursing home rate for ICF holds rather than the present SNF rate which recognizes additional licensing and staff requirements not offered by nursing homes. This, we feel, is going to cause us further financial problems. Because of these regulation changes, we will lose $150,000 from our present reimbursement where we are already providing care that costs more than we are reimbursed.

Also, effective October 1, 1989, there will no longer be a distinction between ICF and SNF level care. The question is, will the hospital be reimbursed for all patients at the lower ICF level? This makes it very uncertain for the continuation of skilled nursing facility at Houlton Regional Hospital, because the requirements are so much more by State licensure and Federal requirements than what we are being reimbursed. So how is HRH going to take care of that population? I don't know. So we need your help there in arriving at a fair and reasonable compensation.

What are we doing differently in the county (Aroostook) that maybe can apply to other rural hospitals? All five hospitals have formed a consortium through a Robert Wood Johnson Foundation grant, which I will give you a breakdown. We are pretty excited about its potential. We are in our first 2-year phase of the program, and we have had some good results. We feel even though we are somewhat competitive hospitals in Aroostook County—if you can call us competitive, most being 50 miles away from each other.

Presently, we are firming up recruitment programs for physicians, RN's, occupational therapists, and other hard-to-place professionals. We are joining forces to recruit for Aroostook County not looking to high paid professionals as our only means of recruiting. Several individuals from our hospitals are being assigned to recruit for the County using different and innovative approaches such as videos, block ads, letters, etc., that we can tell the story of Aroostook County and the needs of individual hospitals, pointing out some of the positive things Dr. Pelli and Dr. O'Keefe were saying about rural areas. We hope that this approach is going to help us. We don't know. We will have to wait and see.

We are at the point now where we are talking about a rural residency program, where third-year residents in family practice will rotate through the Aroostook County hospitals.

Now, I say, by talking I mean we are at the developmental stage meaning that we have not signed contracts, but we have a level of interest we are pursuing through formal channels. A third-year resident, as he rotates through Aroostook County hospitals, if we use national statistics—50 percent of those residents will choose to stay and practice in that town or areas where they received residency training. So we are very interested in pursuing this program. The Residency Program will be through Eastern Maine Medical Center's Family Practice Program.

We are also, through the Robert Wood Johnson Foundation grant, considering borrowing money to offer forgivable education loans to people meeting our needs. So we think that is going to be helpful, as you know, many doctors coming out of school and relocating have large debts—I have one physician I was recruiting last week—that had over a $100,000 in debts coming into practice, and wants to know how we are going to help him make a living and help him pay off his loans since there are very few National Health Corps positions available or being funded anymore. They want to know how much we are going to assist them in addition to income guarantees and I have a difficult situation trying to do that with the limited funds available to us through reimbursement. I would like to say, well, I will write off so much per year for services rendered, but the Government says I cannot support the private price of medicine as a nonprofit institution, so what do I do? I have to be innovative while being legal too, if I am to recruit this physician.

Rural hospitals need help financially to do this. I think we are going to continue to see this kind of indebtedness. Rurals have to respond if they are going to be successful in recruitment.

We are also establishing new educational programs through vocational technical colleges and the university system. We have identified, for example, x-ray technology—we cannot recruit x-ray technicians in the county. We cannot get them, along with some other specialists, so what we are doing, is we are working with Northern Maine's vocational technical college where we are designing a program that is going to educate and train x-ray technicians. That will mean a more stable work force as most students solicited will be residents of the County who will come back to live and work in our communities after they have been trained. We doubt they will go en masse down to southern Maine.

We have also established through the grant a mobile substance abuse program where the unit spends 28 days at each Aroostook hospital. It is an outpatient program—again, an innovative approach. I do not know how it is going to work, but they are running about four or five patients per session, which they feel is progress with a new program that has only been around the county for a short time. So we are anticipating as the program continues, the patient population will also grow.

We will be looking for continued funding for the next phase of this program.

Also being considered is regionalizing of specialty services, we are talking right now about ENT and urology. Why should every hospital have urology; why should every hospital have ENT services? We feel that duplication may be very costly, so we are trying to get together and pool our resources so that we can take better care of the residents of Aroostook County.

Also, we are exploring a computerized countywide clinical and financial data to assist in consolidating services, while improving efficiency and effectiveness of services. What we are trying to do is, look closely at our costs so that we can compare with each other to see who is doing a better job so that the rest of the hospitals can go to that hospital and say, "hey, how come you can do this for less money? Is it possible?" So we are committed to that kind of analysis so we can offer cost-effective services.

We also created a per diem nursing pool which supports all the hospitals in the county with resources of all the hospitals. Houlton may be busy one day and need nurses, but Caribou or Presque Isle or Fort Key may not. So we are paying them more per hour as an incentive as well as mileage and other perks so they will orientate through a general program for all the county hospitals and then rotate to the hospitals having staffing needs.

Again, we do not know if it is going to be successful. Some hospitals believe it will attract adequate additional RN's and some believe it is going to be difficult to get nurses from Fort Kent to come to Houlton even with incentives because that is quite a long trip. But we are trying it. We are fortunate to have some funds to assist us through the grant.

County hospitals have also entered into arrangements through national systems for economical purchase of supplies, consultants, equipment, and so forth. Two hospitals are affiliated with Hospital Management Corporation, formerly affiliated with Hospital Corporation of America; one is with Voluntary Hospitals of America; and one is with Synernet, which is a group formed in the southern part of the State.

Again, this gives us tremendous purchasing power, as well as consultants available to us at reasonable rates to address problems of rural hospitals which we could not afford separate from these systems.

We also do a lot of networking—sharing of resources and ideas—through these systems. There are 9 to 10 hospitals in Maine affiliated with Hospital Corporation of America through different arrangements. We get together on a regular basis. That is very beneficial. We think this process will contribute to helping rural hospitals remain viable. We believe systems are very important for the rural hospitals with limited means.

In summary, HRH sees the need for all those responsible for serving the elderly to work together to make sure that our senior citizens have access to affordable, quality health care. Health providers need to continue in their efforts to provide appropriate quality care that is cost effective and affordable.

The Government, on the other hand, needs to meet their obligations to the elderly through the adequate funding of the Medicare and Medicaid programs. Not to be left out are the elderly and the population as a whole, who need to adopt a more healthy lifestyle so that the system is not overwhelmed and where health care will remain available to all.

Thank you very much.

Representative SNOWE. Thank you, Craig. Paul.

STATEMENT OF PAUL CHUTE, SENIOR VICE PRESIDEN , STEPHENS MEMORIAL HOSPITAL, NORWAY, ME

Mr. CHUTE. Thank you, Senator Cohen and Representative Snowe.

A little bit about Stephens: It is a 50-bed hospital in a rural setting, but unlike some of the remote areas of the State, we are surrounded by cities, and 50 miles from Portland.

Stephens as a rural hospital exists because of a continual collaborative effort between local citizens, medical staff, management, and employees. We have long been recognized as an institution small in nature, but intense in care; recognized by our Medicaid case mix of 1.24; and effective and efficient by our employee ratio of less than four employees per occupied bed, which is significantly less than the average. We routinely maintain an average of at least 85 percent occupancy in our medical surgical wing.

Many years ago, as a collaborative effort, the community determined that the only way rural health care was going to continue to exist in Norway, Maine, was to recruit physicians. We have been successful maintaining an active full-time 36-member medical staff. Of that, 10 are family or general practitioners and 26 are specialists.

It is interesting to note that in the last 2 years, we have extensively tried to recruit family practitioners, but only successful in recruiting one; yet it was easy to recruit specialists, so we acquired three.

Rural communities have the capability of banding together toward a common purpose. Two things which the institution has done most recently that has proven that point: Stephens Hospital experienced within the Maine Health Care Finance Commission a regulatory system that was not designed for what we felt to be low-cost, efficient institutions. We were successful twice, as a community hospital, of going to the State legislature and getting legislation passed that directly dealt with us and subsequently affected other institutions.

Another area that Stephens was successful in was realizing the need for consolidation of costs and buying power. We were one of three institutions originally that established the Synernet group of 17 hospitals which now in 1989 has a buying power of over $25 million, and savings estimated at $1.7 million last year.

Beyond the hospital walls, the community, decided in the early eighties that we had a tremendous problem with drugs and deaths related around our high school graduation process. The hospital collaborated with the high school district, coming up with the brain-child "Project Graduation," which is now a national phenomenon.

Though Stephens is small in nature, we have the opportunity of offering such things as vascular surgery, permanent pacemaker implants, orthopedic surgery, treatments of various levels of cardiogenic shock, and angioplasty.

But there are two things that we think we are doing innovative, at least for rural medicine, that I would like to spend a couple of moments on.

First and foremost would be our home ventilator care treatment. A number of years ago we determined that the home agencies were not capable of supplying us with nurses in order to take care of patients at home on ventilator care. Our nurses, therapists, and physicians sat down with terminally ill elderly patients who would have spent the remaining days of their lives in the institution at excessive cost to the system and to themselves. Through basically teaching the family members how to run the volume ventilators, we were successful in sending patients home, fully aware of all the obligations, risk exposure, and everything. This was obviously done with a high degree of sophistication in backup, support services, both by phone and by location of available technicians to make house calls.

At one time we had four ventilator patients at home on their own, with just the family members maintaining them. Our respiratory therapy department was capable of going in on a routine basis and tracking with the monitors, checking with the family, doing assessments, and completely keeping the physicians updated. Tremendous savings to the institutions, to the system, but preeminently, it was a savings to the elderly person's dignity. They were able to go home and finish the last few days of their life in a setting that was surrounded by family and comfort and things that meant something to them.

A second area that we are trying now and have proven successful in at least our first two tries, is something that is done at Maine Medical Center, but I do not know whether it is repeated in any other rural setting. We have recently tried doing epidural tubes, which is catheterization of a constant pain medication to a person's spine when there is severe pain and the patient is terminal.

Predominantly, the person sits in a hospital setting, occasionally in a skilled setting, and there the family has to come visit them. They are left away from the family, their surroundings and the background which they are familiar with, and they have to die in a foreign setting.

Our anesthesiology department has tried implants and sent the patients home, and the first two tests that we have done in the last couple of months have proven extremely successful. I'm sorry to say that one of those patients has died, but was most gratified to stay at home and say, "At least I'm surrounded by my own environment." That, to them, was what death was about.

Inevitably, you and I—are facing death at some point in our lives. Hopefully, we will live to be as old and energetic as Vera. There are individuals, though who are going to die young—some with severe pain, some with conditions that are more than instantaneous that take years and months. Our system of treating them in nursing homes, in skilled units, in hospitals is adequate, needs improvement, but adequate.

But what we take away from individuals is the dignity of dying. We choose, some of us, to live in rural Maine and that is probably how most of us would like to die. Let us go home. Let us enjoy the things in the surroundings that we have lived with, with loved ones, and when it is time, at least I know what my environment is.

If there is anything that Congress can do would be to enhance the ability of patients to do just that. Keep them out of institutions. Let them go home to die with dignity.

[The prepared statement of Mr. Chute follows:]

Stephens Memorial Hospital
80 Main Street Norway, Maine 04268 207-743-5933

STATEMENT OF STEPHENS MEMORIAL HOSPITAL
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING
AND
THE HUMAN SERVICES SUBCOMMITTEE
OF THE
HOUSE SELECT COMMITTEE ON AGING

September 18, 1989

by

Paul W. Chute
Senior Vice President

Stephens Memorial Hospital is a mix of both small community rural hospital and a progressive regional medical center. At 50 beds, Stephens is small, yet the 65 to 70 thousand patients we treat yearly from our 25,000 population coverage area, suggest a busy medical center.

Stephens exists as a continual collaborative effort of community, trustees, Medical Staff, employees and management. Each supports and pushes the other towards progressive quality care, while within a controlled-cost conscious atmosphere. We have for years been recognized as a cost effective, high intensity, quality care institution but not without many hurdles.

As each stream is forded and crest attained, this highly charged industry offers few plateaus and many more challenges. Others will inundate you with the ills of tne "System" and we share their voice and concerns, but we offer an alternative approach for your committee in viewing the rural health care arena.

Here are some of the major hurdles and resultant strides we have taken in offering "Quality Health Care" to a growing, demanding and evolving rural community.

ISSUE: Community concerns regarding lack of physicians for family and speciality practices. People do not want to drive one hour or more to strange environments for health care.

RESOLUTION: Existing Medical Staff, community thru trustees and management developing needs assessment and resultant recruitment programs. We set our goals high for "top notch" physicians and once successful in acquiring a few, others of like caliber were interested in joining a progress staff. Current active staff of 36 includes:

- 4 Internists
- 2 Radiologists
- 2 Pathologists
- 2 Pediatricians
- 2 Anesthesiologists
- 4 General Surgeons (1 - office practice only)
- 3 Orthopedic Surgeons
- 1 Urologist
- 1 Obstetrician/Gynecologist
- 4 Emergency Services (full time) Physicians
- 1 Occupational Health Physician
- 10 General and Family Practice Physicians

ISSUE: Offering modern, progressive quality health care at affordable costs.

RESOLUTION: 1. Management and local trustees, with extensive and diverse business expertise, ask "what it is going to cost." Efficiency by asking Department Heads to manage frugally as they would their own money.

2. Co-operatively started a group purchasing program with other rural hospitals which has grown to 18 hospitals whose yearly purchasing power exceeds $25 million and where savings for the group are estimated at $1.7 million. Known as "Synernet", this group negotiates contracts for everything from bandaids to reference labs.

RESULTS: Stephens is recognized as very cost efficient as its 3.85 FTE per adjusted occupied bed and its $2,600 cost per adjusted discharge while servicing an average Medicare case mix of 1.2408 proves.

ISSUE: Lack of staffing in nursing and clinical areas.

RESOLUTION: Established collaborative educational program with local vocational high school for Certified Nurses Aides (CNA) training. Worked a training program with local high school audit educational program for CNA students and collaboratively with Westbrook College, for an RN clinical rotation using our hospital as its field classroom.

In addition, we offered job shadowing for local junior and senior high school students to assist in career decisions.

With our affiliated 109 Bed ICF Nursing Home, we offer cross coverage staffing to help with high and low census.

Because our two nearest large hospitals are classified urban, salaries and benefits have had to remain competitive.

Our Respiratory Therapy director is a certified instructor with Southern Maine Vocational Technical Institute and thus offers our hospital as a field classroom.

ISSUE: Community was concerned that all the nursing home beds were being bought up by national for-profit chains or local for-profit individuals.

RESOLUTION: Our parent company, Western Maine Health Care Corporation, a non-profit community directed corporation, with assistance from Farmers Home Administration, purchased a local 109 ICF home that was in poor condition, both fiscally and in patient care, and have turned it around.

Stephens "days awaiting placement" for ICF beds have been reduced and the staffing crisis has been reduced thru staff sharing.

ISSUE: Area/state crisis over Workers Compensation premiums and high injury rates.

RESOLUTION: Extensive discussion with local businesses about their needs and wants combined with our knowledge of Occupational medicine have produced a highly effective program.

We offer pre-employment screening and evaluation for job placement; job functions analysis in the work place; diagnosis of work related injuries; and rehabilitation of workers.

We follow workers and get them back into light duty work as soon as possible. Through constant communication, employers always know where their employees are in the injury/rehab process so that they don't fall through the cracks.

ISSUE: Need for additional non-operating cash.

RESOLUTION: Established annual community fund drive - continually exceeds $75,000.

Created for profit affiliate to sell some of our computer expertise. We offer software and hardware sales and consulting on various levels of data systems.

ISSUE: Problems with rate setting body - Maine Health Care Finance Commission. Low base year rate coupled with steady growth was seriously threatening our financial viability.

RESOLUTION: Drafted state legislation, which the Maine Health Care Finance Commission ultimately supported, that addressed our base year and also the affect that the State's rate setting regulation was having on low cost, growing hospitals. Both legislations were successful because of local public involvement in getting the Commission and Legislators to listen. When complete, they will provide over 1 million dollars in justified relief to Stephens.

ISSUE: Large number of respiratory department (mostly terminal) patients having to stay in the hospital indefinitely, along with oxygen dependent patient who lost contact with their physicians and the hospital upon discharge.

RESOLUTION: Nursing, Respiratory Therapy, Administration and the Medical Staff developed a method of teaching patients and family members how to run and monitor volume ventilators so that patients could go home.

We developed an independent sub-contract with home respiratory therapy companies to do the patient teaching and subsequent follow up care and assessment of the patient at home. By constant interaction with the ventilator and oxygen dependent patients at home, our hospital respiratory therapy department can best assess, monitor and advise the patient about their care but also keep the physician in constant awareness of a patient's progress.

This treating of patients after they leave the hospital offers that "continuum of care" that is vital. This home care also reduces the cost to the system.

ISSUE: Cost of medical procedures and patients having to travel long distances for diagnosis and treatment.

RESOLUTION: Stephens success in acquiring high caliber progressive physicians has expanded the arena of treatments offered.

With a full range of complete joint replacements to angioplasty procedures, permanent pacemaker implants and extensive chemotherapy treatments, our complex and diverse medical offering are seldom duplicated in rural medicine. We are even now offering epidural tubes for terminal pain control for patients at home. Yet these and our extensive ventilator therapy, cardiogenic shock, bowel resections, vascular surgery and intensive care patients are treated at cost well below urban hospitals.

ISSUE: In the early 80's, our community experienced a tragic number of high school student deaths at graduation time, mostly connected with drug usage.

RESOLUTION: Stephens and Oxford Hills High School staff and Administration conceived "Project Graduation", an alternative drug free graduation party. Now directed totally by the high school and extensively sponsored by local area businesses, "Project Graduation" has become a nationally recognized and practiced alternative around senior commencements.

With added incentives from the State of Maine, Stephens established a Chemical Dependency program. Though a hospital program, our director works with and participates in an advisory capacity with the high school drug education program.

SUMMARY:

Rural medicine is diverse in complexity and thus should be evaluated that way.

When hospitals offer such extensive care and at highly competitive costs, is it equitable to pay less? When our workers must be compensated equal to those at urban hospitals twenty-three miles away, does 10 to 15% less in federal allocation make sense?

When faced with diverse issues, this community through local direction and participation have worked with hospital Trustees, Medical Staff and Administration towards successful resolutions.

Stephens Memorial Hospital is classified rural because of its geographic location but practices medicine as if it were an urban referral medical center. With our most recent 1987 Medicare case mix of 1.2408 and our low cost per discharge of $2600, Stephens is not an inefficient "little" hospital.

Thank you.

Representative SNOWE. Thank you, Paul.

Ann.

STATEMENT OF ANN MORRISON, CEO, SEBASTICOOK VALLEY HOSPITAL, PITTSFIELD, ME

Ms. MORRISON. To give you a little background of Sebasticook Valley Hospital, it is located in Pittsfield, Maine. Our hospital is currently licensed for 36 beds, but within about 2 years that will decrease to 28 beds.

The area we serve consists of nine towns with a population of 16,000 people, and while rural in nature—and unfortunately, Paul looked at me when he said isolated; there are days I wish we were more isolated—we have a very diverse industrial base.

The hospital opened its doors 26 years ago when in-patient care was the primary focus of health care. Like other health care facilities, we have had to shift our emphasis to meet the growing demands for outpatient care and same day services. During the last 4 to 5 years we have seen our outpatient revenue grow from 30 percent of our total revenue to over 41 percent of the total revenue. We think we have been fairly successful in making the major shifts from all in-patient care to a very healthy balance of outpatient care.

During my brief presentation, I would like to highlight some of the programs we have implemented to meet the changing needs of our population, both the elderly and the youth.

Because of the size of our facility and the size of the area we serve, it would not be practical to try to duplicate all of the high tech services available in the larger medical centers. I should mention here that Mid-Maine Medical Center sets 22 miles to our south in Waterville, and Eastern Maine Medical Center sets 35 miles to the north. So you can see we are not too isolated. Both of these fine facilities provide a full array of specialty care that complements the services that we try to provide.

In addition, we have many contractual relationships with both institutions. These arrangements allow us to bring clinical expertise to our population that we could in no way afford on our own.

Our hospital has been and will continue to be successful as long as we listen to the communities we serve, we receive fair reimbursement for the services that we provide, and we provide that care in a cost-effective manner.

Our elderly population and the work force that we serve needs care close to home. We have tried to address this need through an active physician recruitment program, the development of specialty clinics, and appropriate outreach services.

Our active medical staff consists of five family practitioners, an internist, and a general surgeon. The internist and general surgeon have joined us within the last year and both have developed very successful practices in less than 9 months. They bring basic specialty care to the local community and eliminate the need for people to have to travel north or south. Their presence on a full-time basis has had a definite impact on quality. They can stabilize emergency patients much more effectively, transfer them if the services those people need is not available in our facility, or care for them close to their families.

Our future recruitment plans include the addition of another family practitioner, a second internist, and a full-time orthopedic surgeon.

Development of specialty clinics held within our facility has also helped to bring better health care close to home. In 1983, we had three specialty clinics. Today we have 14 specialty clinics. The care in those clinics is provided by 20 different physicians from either the Waterville, Bangor, or Skowhegan area. These services are provided on a weekly or biweekly basis. They not only bring the consulting referral services, but specialized diagnostic and/or treatment services to the people in our nine communities. Some of the specialties provided include cardiology, podiatry, neurosurgery, orthopedics, audiology, a hearing aid clinic, physical medicine, urology, mobile ultrasound, vascular testing, diet, therapy, and the list goes on.

To give you an idea of how some of these clinics work, let me briefly describe for you the eye clinic which was started within the last year. Four distinguished ophthalmologists from the Waterville area joined with people in our community and our medical staff and the hospital to develop a part-time ophthalmology service at Sebasticook Valley. Through joint efforts we were able to provide training for our operating room staff, our floor nurses, our admitting department, our primary care physicians, so that we could provide cataract surgery and lens implantation in Pittsfield. They provided some of the equipment. We bought some of the equipment and provided the training for our nurses.

The physicians come 1 week and do the preliminary screening for people who might need cataract surgery. The following week they return to perform that surgery, and the day following surgery, again they return to Pittsfield to provide the initial post-operative visit.

We have now saved the elderly patient, who is already impaired in sight, most likely has loved ones who are working all day and cannot get them to Waterville or Bangor for the care they need, with a service in their own home town.

To date—and the service started in November 1988—we have performed 72 cataract day surgery procedures with lens implantation.

Another service provided by the hospital is the lifeline program. I must point out this is truly a joint effort, for if the hospital had to provide it at its own expense, it would be either at our loss or at a cost that nobody in our area could meet. The effort is between the hospital, the local police department, and a corps of volunteers who install the units into the elderly's home, do the monthly checks, do the maintenance repairs.

At the present time, we are serving 65 people who might otherwise be in nursing homes. This has literally provided them a lifeline, a means of independence. This service is provided within a 25-mile radius and that could be—if we had enough volunteers available—expanded to about a 50-mile radius.

These are just a few of the steps that we have taken to improve the health care available to the Sebasticook Valley region. We are constantly looking for ways to meet the identified needs in a cost-effective manner, but we need your help. The financial and human resource problems all of these gentlemen have alluded to are very real. Our cash reserves are drying up quickly and our physicians and personnel deserve equal pay to their urban counterparts. We cannot continue to add programs unless we receive fair reimbursement for these services. There is a role for rural health care and we need your help to make sure that it is preserved.

I meant to thank you for the opportunity to be here and for your willingness to personally get involved.

Representative SNOWE. Thank you.

I think you are all excellent examples of the role that rural hospitals can play to benefit the people in your communities. As I said at the outset, I was extremely impressed by your operations and the difficult challenges you are facing. But you have anticipated that, and you are attempting to adapt to the changing environment as far as the medical arena is concerned.

I will start with you, Ted. As far as the American Hospital Association is concerned and the board on which you serve, are you coming up with any initiatives or advice that you can provide to rural hospitals to assist them in remaining financially viable?

We know that 86 rural hospitals closed between 1980 and 1986. It is anticipated that perhaps 57 percent may close by the year 1993. I know all these hospitals are attempting to address their shortfalls. (We know one of the problems is the urban/rural differential.) But there are other problems as well. There was a survey that was conducted of the administrators of rural hospitals which closed back in 1987, and less than half indicated it was the prospective payment system.

So there are a lot of issues at stake, and I am wondering if the American Hospital Association and the Maine Hospital Association can provide advice to these hospitals on ways in which they can remain financially viable?

Mr. LALIBERTY. Let me answer it from the American Hospital Association's perspective first. We represent, of the 5,600 hospitals, about 2,000. There are 2,500 classified as rural. We represent 2,000 of those hospitals. There are 18 administrators, peers from around the country elected by each region of the country who sit on that council and give advice to the American Hospital Association staff and what we ought to do.

Mostly recently, we produced several educational booklets, really, guides that can be taken out into the community and help a hospital assess where it is and how it might transition to something different. The problem with all of that, however, is that the community has to have the energy and the human resources to want to lead their organization through that kind of change.

What we have seen, Representative Snowe, is that in many cases when hospitals close, the community truly had no awareness of how close it was to jeopardy prior to its closing and how to stop that. We are doing our best to educate our hospitals around the country to that. We do have programs and brochures that we put out and we hope they are successful. But it really falls back to community resources and the awareness level of folks in that community.

Within the Maine Hospital Association, because we are almost all rural in nature, and small, the Association has always had a focus on small and rural issues, perhaps even to the detriment of the larger or medium-size hospitals. Much in what we have achieved in the State legislature has had a focus on small and rurals. Whenever we are asked to testify, small and rurals are dragged out because they are the sexy hospitals, and not the bigger ones with their larger, more sophisticated services.

So I think there is a willingness on the part of the Maine Hospital Association to deal with those issues, and they have been helpful to small and rural hospitals. But again, it does fall back, the responsibility, to the community. We can help; we can provide tools. They have to have the resources and the willingness to go through the change process.

Representative SNOWE. Would you all agree that the community relationship is very important? And that it has been excellent in each of your cases?

I know that you have all tried to diversify your services, and offer different things to your clients. You have a skilled nursing facility, consortiums, outpatient services and so on. What have you found to be perhaps the most profitable and/or the least profitable service that you have provided?

Mr. BEAN. Probably, I would have to say positively that the SNF unit, the skilled nursing facility. It is a service that we provide which reimbursement helps with covering both my direct and indirect costs. Having a full bed reimbursed rather than an empty acute bed is better but I think in providing an excellent service where we are reimbursed at far less than the cost of providing that service is negatively impacting the hospital financially.

SNF reimbursement has been iffy all along. But I think now with these changes I mentioned in my notes, of ICF hold rates and one single rate in 1990, I am even more concerned whether I can continue in the SNF business. That would be what would jump out in front of my mind right now.

Representative SNOWE. Are there any other rural hospitals that provide skilled nursing?

Mr. BEAN. Yes, but many hospitals have closed units. I think the Aroostook Medical Center in Presque Isle has some beds besides Houlton in the county. But hospitals have gone in and out of providing the services because of reimbursement and regulations. We have stuck with the service right from the beginning, realizing what a valuable service it is to the population we serve. But it is not a winner, financially, in fact, I don't know what is today in health care.

Representative SNOWE. I can appreciate that, because in my visits to hospitals, I have found that everybody is trying different things. But what I have also discovered in visiting hospitals is the fact that there are many people who are in a holding pattern in these hospitals because there is no place to go.

Do you, Paul——

Mr. CHUTE. Have any areas that are losing a lot?

Representative SNOWE. What is the most profitable venture that you have?

Mr. CHUTE. I don't think we found any.

Representative SNOWE. But you made money on Medicare, which is something very few hospitals can say.

Mr. CHUTE. We have been lucky. Since the prospective payment system came into place in 1984, we have made money every single year, but only because of cost-conscious management. It obviously took a tremendous amount of effort in coordination with all the things, medical staff, methods of practice, and everything else.

What we have lost most in, I would say, were any programs that related to the recruitment of physicians. We have rural communities who needed a local physician. Through an affiliated corporation, we were successful, at least in the short term. The regulations and the reimbursement systems were such that we could not afford to keep them there, and we had to shut them down.

You cannot find physicians unless you are willing to somehow make them believe they are guaranteed $80,000 to begin with. For small institutions to come up with that type of support is very, very difficult.

Representative SNOWE. Do you have any vacancies on your staff as far as physicians are concerned?

Mr. CHUTE. We could handle three family practitioners, an internist, and an emergency room physician today, and we have been recruiting extensively for them indefinitely, because every time we find one, with the area growing, we need another. The last couple of years, we have had two go back to school for advanced specialty training. So it is a constant problem.

Representative SNOWE. Ann, I know that you have really worked hard to increase your outpatient services. Can you tell us what has been the most profitable and the least profitable service?

Ms. MORRISON. The least profitable, unfortunately, I think is the in-patient side, because of our high concentration of Medicare patients. The more we can do to make that a more even blend to the patient census, the better off everybody will be.

The most profitable has been the outpatient side. But I really wonder how long that is going to last, because those screws are being tightened, too.

Representative SNOWE. But outpatient has helped offset——

Ms. MORRISON. It has been very good to us because of the spinoff, not so much because of any fees that are charged to those specialty clinics, but because of the spinoff that we see in our day surgery program, laboratory, x-ray, physical therapy, and some of the other services that a hospital provides.

Senator COHEN. Just a couple of questions.

But first, I might say that, while you were testifying, my folks came in to the audience. I want you all to know that I deliberately did not ask my father as a witness because he refuses to go to a hospital and he refuses to see a doctor. Therefore, I thought that his would not be very constructive testimony.

Ted, you mentioned something during your testimony about you, we, in Maine serving the uninsured or underinsured, no matter what. But when you do that, what does that mean for the other patients? Let's suppose someone comes in—we feel an obligation to provide this service—there is no reimbursement, no payment. What do you do?

Mr. **LaLiberty**. I suspect you already know the answer to that——

Senator **Cohen**. I am just trying to put it in the record.

Mr. **LaLiberty**. It is called cost shifting, and what you do is, you add a surtax or a surcharge on to other patients who have insurance or who can afford to pay, except for the Medicare patients and the Medicaid patients. They will not participate in that surtax.

Senator **Cohen**. Are you finding now that the business community is starting to revolt and say, "Wait a minute—we are not going to offer these health insurance programs. They are simply too expensive, because the cost of those who are uninsured is being borne by us. The premiums are getting too high, and it is just not worth it for us anymore"?

Mr. **LaLiberty**. Your statement is correct. What we are finding is that it is a Catch-22. As you begin to shift that surtax onto other payers, the cost of health care insurance rises, therefore less people can afford it, they are dropping their insurance, therefore there is an increase in the underinsured, and the circle repeats.

Senator **Cohen**. Craig, I was interested in what you said about some of the new technologies coming through. We have heard testimony this morning about CAT scan mobile units going through communities. MRI's, I'm told, are now coming into greater use. That is a very expensive proposition, is it not?

Mr. **Bean**. Aroostook County does have a certificate of need for MRI service, a mobile unit for all five hospitals. It is outside the Robert Wood Foundation Grant, but the hospitals together are working with CT Shared Services headed by the radiologist at Houlton Regional Hospital.

This group also provided Mobile CAT Scan service to the county, which has been very successful for them and for us, too.

So we are now going that next step. We feel at least from the preliminary financials, that it is going to be a very, very risky service, although we feel it is a necessary service. It will help the physicians do a better job. So I think we are going to go ahead and do it—that close, and if we get the certificate of need approval, we will be reimbursed for the costs of providing the service.

Senator **Cohen**. Paul, did I understand your testimony? Did you say that it is easier to get specialists than to get general practitioners or family practitioners?

Mr. **Chute**. Yes, it has proven that way in the last couple of years for us. We have such a high speciality base, and in my written testimony—we would like to think it is because we found a few real top-notch specialists to begin with, then it is easier for them to attract other specialists to come. Once you get over a hurdle, then you have two specialists, the third one tends to come quicker because of the coverage.

Senator **Cohen**. Is there also a financial aspect to it whereby a specialist says, "I can go into a small community like Norway, and I can still make a reasonably decent living because I can charge more, no matter what, than a general family practitioner"?

Mr. **Chute**. I would not want to speak for a physician, though they constantly tell me that they could make twice as much were they to go to the Lewiston or Portland setting. They tend to feel that they are making adequate incomes, though they would like to have more to satisfy whatever needs they have, but there is something about the rural setting that adds quality of life to them that money just cannot answer.

Senator COHEN. Is it the Medicare prospective payment system with its diagnosis related groups (DRG's) which has driven your hospital to increase outpatient service? Are hospitals failing now because they do not have the inpatient population—because the DRG's are driving everyone to outpatient care?

Ms. MORRISON. I do not think that is the only reason. I think the very thing you alluded to before, employers, major employers looking for a more cost-effective way of providing health care is another reason. If you can get the same service on an outpatient basis rather than spending a day or two in the hospital, then that is the way we should be going.

Senator COHEN. I couldn't help but notice over the last several weeks, that all the major networks have been focusing upon the drug problem throughout the country. Some of the shows have been truly astonishing. It looks like a MASH unit in some of the urban intercity hospitals.

One program had a segment on a hospital in San Francisco. The emergency room staff were bringing cocaine-overdosed patients in and they were talking with them. It was really horrific to look at. They were talking about treating those patients, all the other patients are being shuffled aside—heart attack cases, broken arms, emergency types of treatment—just put off in the corridor while they treat the drug afflicted individuals. Then that individual will go out after being detoxed, or whatever, and have about a 14-minute interval before he gets hooked again.

I am wondering whether or not—even though we have a wave of drug problems coming to our own shores—whether or not that sort of burnout is going to be driving more and more physicians into rural communities who say, "We don't want to deal with this kind of problem any longer."

Is that something—not to take advantage of somebody else's problem—that might encourage physicians to come to rural areas?

Ms. MORRISON. I think you are assuming that the problem is not in the rural areas, and that is not a safe assumption.

Senator COHEN. Is it as severe as what we have been witnessing on television?

Ms. MORRISON. On a proportionate manner, yes.

Senator COHEN. Everybody agree with that?

Mr. BEAN. No, I do not. We have had very few cases come to our emergency room. In fact, I asked before I came down here. Something like last year we had only two patients in the hospital who came in for overdose. That is amazing. I don't know why. Maybe they are going someplace else, or not being treated at all.

Senator COHEN. Going to Pittsfield?

Mr. BEAN. I am amazed at the low occurrence.

Mr. CHUTE. That is an interesting note, because the medical studies that our physicians have done and those which are national indicate that 33 percent of our admissions are drug-dependent related. So to say that it is only an urban phenomenon is not correct.

Senator COHEN. Just one final thought—we are running a little bit behind schedule—but I was reading the Smithsonian Magazine a few months ago. I don't know if you saw it, but it featured an article that was really a very powerful statement about the benefits of a rural hospital. It was written by an individual, Mr. Margolis, who was once vacationing on an island off the coast of Maine, when his son had a medical problem which was treated at St. Andrews in Boothbay. I think we will insert this article in the hearing record as well.[1] Mr. Margolis said that rural hospitals are "where no one is a number; where everyone knows your name, tolerates your quirks and shares your griefs; where the nurses celebrate your birthday. Where, when you telephone to say you feel sick and wish to be admitted, they turn down your bed and have the florist deliver a half-dozen pink carnations to your room. Where visiting hours do not matter, even if they are posted—relatives and friends come and go as they please; where a turned-on light over your door instantly brings a nurse to your bedside. Where the kitchen staff makes bread and pies from scratch"—Dad, you'll be happy to hear that—"and real mashed potatoes and if you don't like the evening menu, someone will run to the corner and bring you a pizza with mushrooms and onions—and no anchovies."

Then he says, "From them I conclude that small-town hospitals draw energy from secrets all their own: within the national health care system they emerge as unique institutions where the curing and caring are one and indivisible."

That is a very poignant statement and I hope that we can get that message to our colleagues. Thank you all.

Representative SNOWE. I think that sums it up very well.

I want to commend you again for your herculean efforts in the face of a very difficult environment. I really am impressed. I can't say that enough. Thank you all very much.

[Whereupon, a short recess was taken.]

Representative SNOWE. One more panel.

First of all I want to announce, because I think it is pertinent to what we are talking about here today, that the Blue Hill Memorial Hospital is being awarded a $50,000 grant under the Rural Health Care Transition Grant Program of the U.S. Department of Health and Human Services. I think it is an excellent program and I am so pleased that Blue Hill Hospital was awarded this grant.

Part of their plan is to develop transportation outreach programs to increase access to health care. It is to staff and to equip mobile vans to go to senior centers and nursing homes to perform diagnostic and preventive tests. This would include tests for blood pressure, cholesterol, and osteoporosis.

I want to congratulate Blue Hill. Congratulations to both of you. It is great.

The third and final panel will examine the health care needs of the rural elderly and alternative sources of health care.

First, we have Nona Boyink. Nona is the past president of the National Rural Health Association; president of the Maine Ambulatory Care Coalition; and president of the Kennebec Valley Regional Health Agency. As such, she offers a national as well as local perspective on the problems inherent in the rural health delivery system and the ways in which these challenges can be addressed.

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[1] See appendix, p. 87

Chris Gianopoulos. Chris serves as the director of the Bureau of Elder and Adult Services, which was formerly known as the Bureau of Maine's Elderly. As Maine's State Unit on Aging, the Bureau of Elder and Adult Services plays an important role in addressing the health care needs of the elderly who live in rural areas. The aging network has been involved in many collaborative efforts with rural hospitals and providers to ensure that our rural elderly have access to health care.

Ruth Lane. Ruth is the vice chair of the Rural Health Centers of Maine. These centers provide a wide range of primary care services and also place significant emphasis on health promotion and preventive services. They play a crucial role in assuring access to health care in rural areas.

Finally, we have Hilton Power. Dr. Power is vice chair of the Maine Committee on Aging. The Maine Committee on Aging serves as the State-appointed advocate for elderly citizens. As such, they have a deep concern for assuring that the rural elderly have access to affordable quality health care.

I want to welcome all of you here today, and why don't we begin with you, Nona.

STATEMENT OF NONA BOYINK, PAST PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION; PRESIDENT, MAINE AMBULATORY CARE COALITION; PRESIDENT, KENNEBEC VALLEY REGIONAL HEALTH AGENCY, WATERVILLE, ME

Ms. Boyink. Thank you very much for inviting me here today. This has really been quite encouraging to see a number of people focusing on the problems of rural Maine.

The speakers that have gone before have elucidated many of the problems quite well, and I think both the advantage and disadvantage of coming later on in the panel is that I can cross off half the things I was going to say, but I have also been making notes furiously to emphasize some of the points that they have made.

I assume that I have been invited particularly to talk about what are affectionately known as "alternative systems" for delivering health care to the rural elderly. Through my work, both nationally and here in Maine at Kennebec Valley Regional Health, I am deeply involved in two parts of those alternative systems.

K.V.R.H.A. is a private, not-for-profit corporation located in Waterville. We provide three types of health care: home health care, substance abuse treatment, and primary care through rural community health centers. Two of those areas are particularly crucial to the system of the delivery of health care in rural areas: home care and rural community health centers.

I think that many of the problems that have been addressed this morning about the particular health needs of the elderly are not necessarily unique to the rural elderly, but they are significantly compounded for those elderly living in rural areas. The need for physical access on a geographic basis to health care at all levels, but particularly to primary care and preventive health care, is very, very critical, and one that both home care organizations and the network of community health centers, both nationally and in Maine, can help to address.

In Maine there are over 23 federally funded community health centers, and a number of independent community health centers. There are also over a dozen Medicare-certified home care agencies. Although they are termed alternative sources of health care, they really form the backbone of the care in rural Maine. These different types of care have to work cooperatively and in a coordinated effort with other providers in the region.

I would like to give you a couple of examples of how that can happen in both those instances, and then just address briefly some of the significant concerns for those two systems.

I spoke this past winter, in an effort to do some long-range planning, with 15 of the physicians that are on our Rural Community Health Center staff, asking them to identify health problems in several age groups that they felt they had the most difficulty treating because of a lack of resources. To a physician for the elderly population, mental health services and preventive health services were the two problems that they felt needed the most attention in a rural setting. Preventive care, as many people have alluded to this morning, simply is not reimbursed by Medicare.

Accident prevention—Mrs. Johnson was talking about her fractures. Many people end up in long-term care because they fall in an unsafe environment, their home. Some sort of reimbursement that would allow an assessment of that home that would prevent that accident would save thousands of dollars to the health care system and many, many months of pain and agony for the rural elderly.

Mental health services frequently are not even identified as a need by the elderly person because of the social stigma attached to receiving such care and counseling. Many of those mental health needs are organic in nature, but many are environmental, and they can frequently be discovered in a primary care setting.

We are participating now in a demonstration project through our community health center in Livermore Falls, the Western Maine Family Health Center, with the Bureau of Mental Health, through the State here in Maine to place a geriatric mental health worker on the primary care team in the rural community health center to help sensitize the primary care physicians to some of the potential mental health needs of the elderly, and also to make that service available in a setting that is comfortable and familiar to the elderly person.

A family doctor is a very comfortable place for an elderly person to go for health care, and if that family doctor, through a community health center setting, can bring a number of services into the community and offer them to the elderly person, the elderly will take advantage of those.

Preventive health becomes a real crucial issue when you talk to these physicians, even though the general population seems to think that preventive dollars may be wasted on the older person. You know from your efforts on the Mammography Bill that again and again prevention saves dollars and lives.

An interesting example—I think of Dr. Pelli and his questions about annual exams—we are fighting with Medicare now in one of our rural health centers where our physicians, in an attempt to make sure that preventive care is provided and save travel, transportation, and trips to the doctor for their older citizens, are combining a preventive health maintenance physical with one of their return visits for their hypertension, diabetes, or heart disease. Because it says health maintenance exam in their chart, or annual physical, all of those visits are being denied by Medicare, even though care for a significant problem was provided at the same time.

Either we do not write in the record what we did, or the people have to come back at another time for care. They probably won't do it. If they have to pay for it out of pocket, they definitely won't do it. I think those kinds of issues, that really are regulations and require some flexibility, can solve a lot of problems in delivering care.

Mrs. Lane is going to talk some more about community health centers, so I will talk just briefly about home care and then let the rest of the panel move on.

Home care is one of the ways that we are addressing, indirectly, the problems that rural hospitals are having, because patients are coming out of those hospitals much more acutely ill than they ever were before.

We now have to provide 24-hour nursing service through our home care agency because patients go home with IV lines that must be maintained, they go home on respirators. That is easy to do—well, it is not easy to do, but it is possible to do in Waterville, it is possible to do in Skowhegan, it is even possible to do in Bingham but we also provide care to Jackman.

Our nearest office for home care is in Bingham, where we have one nurse who is the home care nurse. There are two registered nurses that live in Jackman, one of whom works in the nursing home, the other of whom works part time for us.

We recently had a patient from Jackman who could have been discharged from the hospital had someone been able to maintain the IV line overnight. You cannot do that from 60 miles away in Bingham, and you cannot expect one nurse to be on call 24 hours a day, 7 days a week to care for that person. So that person had to go to a nursing home, perfectly capable of living at home except for the IV line.

Now, if there were flexible reimbursement available that would allow the home care agency to cooperate with the outpatient department of the hospital which maintains a small health center there, we might be able to bring enough resources to bear in Jackman that those 800 people could have access to just about the same kind of home care services for the elderly that folks from Waterville and Skowhegan have.

I think we really do need to look at the flexibility of regulations and work on reimbursement systems that encourage cooperation rather than having us all fight for the same piece of the pie. I think that is a real fear that everybody has when you start talking about—for instance, about which parts of a hospital make money. Well, now, those parts of the hospital that make money, might mean that I lose money. Instead, we need to be thinking about how can we as providers can all be responsible for an area to make sure that the care stays there.

The community health center system is severely threatened under this year's budget discussions. The House appropriation is level with last year's. The President's request is level with last year's. That means, probably 20 to 25 community health centers are going to have be defunded if the rest are to maintain the same level of services that they are currently providing.

Over half of the community health centers in Maine are over 10 years old. They have equipment that is over 10 years old. They have buildings that are over 10 years old. There is little to no access to capital for them. Public Health Service regulations do not permit funded depreciation of that equipment, which means that there really is no way to replace that, and if the appropriation remains level, there will be no improvement for those community health centers.

I would ask you both as you look at pieces of legislation in front of you to be particularly aware of new pieces of categorical funding which are set aside for community health centers. I am thinking particularly of the homeless legislation, legislation to improve infant mortality, legislation for AIDS, and substance abuse. It makes it look like community health centers are getting a lot more money, and urban community health centers are, but rural community health centers cannot compete effectively for AIDS money, for substance abuse money, for homeless money. That means that in effect our funding decreases over the long run.

[The prepared statement of Ms. Boyink follows:]

Testimony
of
Nona Olson Boyink
President/CEO
.ennebec Valley Regional Health Agency

Senator Cohen and Congresswoman Snowe,

Thank you very much for the opportunity to provide testimony today concerning the delivery of health services to the rural elderly. My name is Nona Boyink; I am the President and Chief Executive Officer of the Kennebec Valley Regional Health Agency, a private, not-for-profit corporation located in Waterville, Maine. Regional Health provides health care services of three types: home health care; primary care through rural community health centers; and substance abuse treatment in Somerset, Franklin and Kennebec Counties. Additionally, I am currently the President of the Maine Ambulatory Care Coalition, an association of community health centers in Maine, and I am a past President of the National Rural Health Association, so my remarks are based not only on the experience of Regional Health as a direct provider of care, but on the experiences of my colleagues statewide and nationally.

Problems of delivery in meeting the health care needs of the rural elderly are many and require creative solutions and joint efforts on the part of many providers of care. Your hearing has brought together many of these providers and, hopefully, this will encourage each of us to expand our horizons to work with one another to maximize resources in rural areas.

While the health problems of the elderly as a population are many and, I am sure, well known to both of you, there are a few issues that are exacerbated for these elderly who live in rural areas like Maine. Some of these issues fall into the category of health problems, others into the category of process or system problems. I will talk briefly about health problems first since they are exacerbated by systems problems. I will then briefly discuss ways in which alternative systems provide some solutions.

First, let us look at health problems. As we all are aware, serious illness and chronic disease are more prevalent among the elderly. Diabetes, hypertension, heart disease and malignancies cause significant morbidity and mortality among the elderly and place high demands on their financial and family resources, as well as on the resources of their communities. There are also three areas of health problems which are prevalent to a significant degree among the elderly population but which receive much less attention. They are mental illness, substance abuse, and accidents.

The elderly, and particulary the rural elderly, are lonely and isolated. This frequently results in depression which may result in loss of appetite and lack of attention to personal care. Their health deteriorates and it becomes a downward spiral. At other times, mental illness can develop for specific organic reasons or perhaps because a person is in very poor health or has a terminal illness. Suicide or suicidal ideation is not uncommon. Substance abuse is also at issue, most frequently in the form of alcoholism that goes undetected due to isolation and withdrawal from activities. Of particular concern is the abundance of accidents among the elderly, especially those that occur in and around their own homes. Accidents for the elderly frequently mean serious injury and long-term disability and threaten their ability to remain at home. What is most distressing, of course, is that almost all accidents are preventable.

These three areas of concern are exacerbated by several systemic problems, including a relative lack of health care in rural areas; lack of transportation to health care that does exist or exists in distant population centers; and a lack of reimbursement for preventive care.

Nationally, approximately 24% of the US population lives in rural areas, while 29% of the US elderly population lives in rural areas. Additionally, recent studies show that as the size of a place decreases, the proportion of the elderly increases, bringing even greater burdens to bear on already scarce resources. For example, while rural elderly who are significant users of the health care system live in rural areas in large proportions, rural hospitals get only approximately 9% of the reimbursement pie.

Additionally, because of traditional forms of establishing Medicare fees, rural physicians are paid disproportionately low fees for services identical to those provided in more uban areas. These economic issues contribute significantly to access problems for elderly who live in rural areas because they impact on the ability of those areas to recruit and retain high-quality health care professionals, including primary care physicians, nurses and ancillary staff such as physical and occupational therapists.

In a study published recently in Health Affairs, David Kindig, M.D., of the University of Wisconsin has documented that the physician to population ratio in small rural areas is decreasing dramatically relative to that ratio in urban areas despite the growth in physician supply nationally. Since many other factors such as the urban/hospital orientation of medical education, professional isolation, etc. already put rural areas at a disadvantage when recruiting, we must remedy the economic inequities immediately and also support programs such as the National Health Service Corps which help enhance rural areas' abilities to recruit professionals.

Transportation for rural residents, but particularly for the elderly, creates a particularly complex problem as you documented on your recent visit to Maine, Congresswoman Snowe. The elderly are scattered far and wide and yet need care when they need it, not when a rural once-a-week shuttle runs.

The solution to many of these issues is to strengthen our primary care and home care network in rural areas, and to create incentives for all providers to work together. Fortunately, in Maine, in addition to our excellent rural hospitals, we have a network of over 23 rural community health centers and more than a dozen Medicare-certified Home Care agencies. Although it can frequently be more expensive on a per person basis to provide care to a widely scattered population, delivery systems such as those established by community health centers, which bring many resources into an area, are an excellent answer to taking multiple services into small population groups. By combining services under one roof, community health centers help provide some of those economies of scale to a number of different services such as health education and prevention activities, which can help alleviate accidents and increased hospitalizations from chronic disease. However, providing preventive care to the elderly is very difficult under the current reimbursement system. For example, a visit by a nurse or social worker to an elderly person's home could easily uncover unsafe conditions such as scatter rugs, broken steps, et. Such a visit would cost very little compared to the treatment of a broken hip. Medicare will pay for the hip repair, but not such a home visit. This is a problem that holds true in urban as well as rural areas, because the Medicare policy is to not pay for preventive care. A recent, frustrating example of this is the experience we have had in one of our own rural health centers where, in an effort to save patients a trip to the doctor and to make sure that preventive care is provided, our physicians routinely provide a health maintenance examination in conjunction with one of the many necessary return visits that happens in the course of a year for hypertensive and diabetic patients, rather than scheduling a separate annual exam. Because the notation was made in the chart that health maintenance exams were also performed at these visits, which were primarily intended to assess the status of the patient's hypertension or diabetes treatment, Medicare has denied payment for all of these visits.

Currently, most of Maine's community health centers provide a location for the provision of limited substance abuse counseling, but most counselors have long waiting lists and other mental health services are desperately lacking. There is, however, an interesting and relevant demonstration project funded by the Maine Department of Human Services, Bureau of Mental Health & Mental Retardation. It is a joint effort among the Bureau, the Western Maine Family Health Center, Tri-County Mental Health Services, and the Maine Ambulatory Care Coalition, to examine whether the elderly can be more appropriately assessed for the need for mental health services and will be more willing to utilize those services if access is provided through the primary care system in a rural area. The premise under which the demonstration project is operating is that the elderly are comfortable within the primary care system. There is no stigma attached to receiving care through that system and, frequently, it is the only contact they have with anyone who could assess their basic mental health status. By incorporating an awareness and potential assessment into each visit that an elderly person makes to a primary care provider, it may be easier to identify potential situations which could lead to mental health crises or identify substance abuse and other mental health problems which are amenable to treatment. If the primary care provider can then refer the elderly person to someone within the same facility, it is more likely that the person will be willing to go for care. This rural, geriatric mental health program is one in which we are all extremely interested, and we hope to pursue some additional funding on a larger scale, perhaps a federal demonstration project, if the initial pilot in Maine is successful.

Home care services to the elderly are becoming an increasingly critical part of the health care delivery system. Complex reimbursement and a continual assault on the level of Medicare funds available for long-term care intensifies the problem nationally. As the acuity of patients discharged from hospitals increases and the intensity of nursing provided by home care nurses necessarily must increase, the problems for the elderly living in rural areas are exacerbated. Patients are now frequently sent home on respirators or with I.V.s requiring around-the-clock care. This is very difficult to provide in small, isolated communities where the current nursing shortage seems to hit hardest. Our home care service provides 24-hour call for patients on I.V.s; however, in order for that call to be effective, we need to be able to respond to a call within 15 or 20 minutes if there is a problem in the middle of the night. An exteresting example is Jackman, Maine. We do not have a home care nurse stationed in Jackman. There are, to my knowledge, only two registered nurses in Jackman, not all of whom are interested in working in home care. This means it is basically impossible to provide 24-hour I.V. coverage through the home care nursing system in Jackman since we cannot expect one nurse to be available 24 hours a day, seven days a week. Additionally, our nursing staff out of Skowhegan or Bingham cannot respond within an appropriate amount of time over that distance should there be a problem with an I.V. line. The solutions to a situation like this are cooperation among institutions and providers and supportive reimbursement policies. There is a small health center in Jackman that is part of the outpatient department of MMMC in Waterville. Perhaps through cooperation between that health center and the home care service, patients would be able to go home to Jackman with I.V.s and needing access 24 hours a day to a skilled level of care if reimbursement systems were more flexible.

I believe that the particular problems in providing health services to the rural elderly center around the need for systems of health care which provide not only traditional medical care, but health education and preventive care, and a multitude of services related to mental health and substance abuse services, which are hard to provide on a small scale. These organized systems such as partnerships among community health centers, hospitals, and home care agencies can also provide a better base of support when attempting to recruit and retain health care providers. Many of these problems are not unique to being elderly, but they are unique to rural areas. I know that each of you participates in your respective rural health caucuses in the Senate and House and are very aware of the issues facing rural health care in general today. We all appreciate your support and concern for efforts to improve the delivery of health care in rural areas, and clearly a very important piece of that activity in the State of Maine is the position that rural community health centers and home care agencies have. Twenty-three rural health centers providing service to residents of over 100 communities are a significant portion of the health care system of the State as a whole, and a major portion of the health care system in the more rural and isolated portions of the State. Ongoing support for the community health center system and support for its integration into the health care system, as an active partner with hospitals, home care agencies and private practitioners, will be crucial to the long-term survival of a good health care system in the State of Maine.

Thank you for inviting me to testify. I look forward to helping in any way I can with your efforts to improve rural health care to Maine's elderly, and I look forward to working with my colleagues in strengthening our health care system for rural Maine.

jl

Representative **Snowe**. Thank you, Nona.
Chris.

STATEMENT OF CHRISTINE GIANOPOULOS, DIRECTOR, BUREAU OF ELDER AND ADULT SERVICES, MAINE DEPARTMENT OF HUMAN SERVICES

Ms. **Gianopoulos**. Thank you.

The Bureau of Elder and Adult Services assists adults to maintain an independent lifestyle in their homes and communities. We administer community-based programs for older adults as well as protective and guardianship services for adults of all ages. Services for older adults are managed by Maine's five Area Agencies on Aging, one of which Vera mentioned this morning. The area agencies serve as focal points in the community, providing information on and access to a wide range of benefits and services such as home health care.

I have been asked to speak today on how Area Agencies work with hospitals.

The Medicare prospective payment system, which has been mentioned a number of times this morning, coupled with the centralization of technology and medical personnel has contributed to a major change in the health care delivery system. Hospital discharge rates have fallen sharply for elderly Medicare beneficiaries. A greater reliance on outpatient care for medical problems previously treated on an in-patient basis appears to be the primary reason for that decline in utilization.

For older people in Maine, this change has created a need for services like transportation, temporary housing, and home care in ways that were not necessary when the hospital was closer to home or hospital stays were longer.

Senator **Cohen**. Chris, could I just interrupt you for a second and ask you, has that change been for the better or for the worse in terms of forcing more emphasis on outpatient care as opposed to in-patient care? Has that been more beneficial or more detrimental, in your assessment?

Ms. **Gianopoulos**. I think on balance, for people who live near a hospital, it has been positive. I think most people recuperate better at home in a familiar setting. The problem is for the person that I would like to describe, a typical 83-year-old man who lives in Allagash who needs cataract surgery. He has to go to Bangor, expected to arrive early in the morning—we are talking about a 200-mile round trip—return home the same day, come back the next day to have the bandages removed and the surgery checked. If he did not live in Allagash, it would not be an issue. But it is the getting back and forth.

I think Mr. Gallagher, this morning—a real problem is for people who live in Washington County. The nearest chemotherapy and radiation is in Bangor. I think a lot of people, especially older people, simply forego necessary treatment because it is just too much trouble to make the necessary arangements.

Community programs also have not caught up with the changes in health care delivery systems. Often when a hospital staff person asks an older person if they have adequate help at home, the person may overestimate their ability to care for themselves or, more likely, they are simply reluctant, pretty independent, and they are not going to ask for help.

What happens then is they may realize shortly before it is time to go home that they are a lot sicker than they thought they were going to be. The hospital staff then has to scramble around at the last minute trying to put together some home care services.

The Area Agencies and Maine's hospitals recognize these problems and they are working on some solutions. I would like to just give you a few examples.

In Aroostook, the Houlton Regional Hospital and the Area Agency are sharing a staff person who does discharge planning for the hospital and care management for people when they go back to the community.

The Eastern Area Agency and the Penobscot Valley Hospital have recently opened a new community meal site.

In Central Maine, staff from the Area Agency regularly attend patient rounds at several area hospitals which enables them to identify people early who may need home care.

Mid-Maine Hospitals and the Area Agency also operate an adult day care program for patients who are in the hospital awaiting nursing home placement.

In Southern Maine, the Area Agency is cooperating with hospitals and our Adult Protective Program to develop a single protocol for referral of elderly patients who may be abused or neglected.

Given the scale of the health care, geographic and demographic challenges facing our State, no system can afford to operate in isolation anymore. Our Bureau will foster additional collaborative efforts through a $250,000 grant from the Administration on Aging that we are calling Project Maine Neighbor. The goal of Project Maine Neighbor is to assure that older citizens have access to the hospital based health care they need. Each Area Agency on Aging will target specific aspects of the statewide health access problems within its geographic region. Each will collaborate with public, private, and civic organizations to help find solutions. The Bureau's job will be to expand those solutions on a statewide basis.

Project Maine Neighbor will tap into new and existing volunteer resources.

We really see the project as a good opportunity to recreate the community, State, and health care services for older people.

I would like to just simply close by reemphasizing some of the recommendations you have heard already, one of which is more flexible Medicare reimbursement for community-based services. That has improved in the last year or so. We have seen a big shift in that, and I think we need to do more in that direction. Most of the funding for home care for the elderly in Maine comes from the State legislature, and our coffers are beginning to run dry.

I think a more creative use of technology is something else we need to look at. Are there ways we can bring services to people in an affordable way?

Third, more geriatric training for physicians is really important. Thank you.

Representative SNOWE. Thank you, Chris.

Ruth.

STATEMENT OF RUTH LANE, VICE CHAIR, RURAL HEALTH CENTERS OF MAINE, INC., AUGUSTA, ME

Ms. LANE. I thank you for inviting us. We are a unique setup. It took many years to get to what we are. Rural Health Centers of Maine is a network consisting of a central administrative office and seven rural community health centers. This network of centers serves a population of over 41,000 people living in 54 communities. All seven centers face a demand for primary care which exceeds the total available supply of services.

As the primary source of care in its service area, each center faces the charge of attempting to provide or coordinate all care to all people. In order to meet this charge, the scope of services provided by the centers has grown and needs to expand even further.

Each of the seven centers is located in an isolated, rural area of the State designated as a medically underserved area. Most travel to receive any medical care in these areas is over secondary roads and is additionally hampered by extreme winter weather conditions. Primary hospital care is provided by small rural hospitals, all of which are facing increasing obstacles to continuing functioning. The average distance between a center and a tertiary care hospital is 92 miles, with an extreme of 150 miles.

Each center stresses family oriented, preventive care where health promotion and disease prevention activities are offered as ongoing aspects of individual care and organized community events. The centers are staffed by 12 physicians and 8 mid-level practitioners, each of whom is board-certified.

Retention of provider staff is difficult in these areas where personal and professional isolation is so severe. In just this year, 10 of the 20 providers are new. In order to serve these communities, providers give up much of their personal time—a strain contributing to the high burnout and turnover rates. Providers need to be available 24 hours a day. Coverage of hospitalized patients is difficult, given the time required to travel to and from distant hospitals. Individual incomes are lower for rural providers than for their urban peers. The sparse populations coupled with high rates of poverty do not afford the possibility for higher incomes. Even though all these centers receive Public Health Service funding to partially support provider salaries, these funds are limited and do not increase proportionately to cost-of-living increases and the need to remain competitive with urban practice opportunities.

While all these factors lead to high provider turnover, they are also a deterrent to recruitment. In the past, professionals have been available for assignment to these areas through the National Health Service Corps. Even with the National Health Service Corps, some centers have undertaken recruitment campaigns which have required in excess of 1 year to result in hiring.

One national recruitment firm has established that currently there are 10,000 to 15,000 family practitioners being recruited. Residency programs are graduating only 1,600 of these annually to fill this need. Less attractive, rural areas will not be able to compete in this environment.

Equal to the need for physicians is the need for mid-level practitioners. These professionals have consistently been proven to be a cost-effective option for providing primary care. They generally have better retention rates in rural health center areas than physicians. They are welcomed in the communities and are well received by patients. However, they have become very scarce.

Health centers must now compete with hospitals, health maintenance organizations, and urgent care centers to recruit mid-level practitioners. These urban facilities are able to offer working conditions and salaries which are far more attractive than those available in rural areas.

We urge consideration of any and all efforts to address the health manpower shortage facing rural America today. Without manpower, services will decrease; less care will be delivered early in an illness; acute care will increase. Decreased manpower will eventually lead to sicker people cared for in more intensive care settings, resulting in huge increases in medical costs.

As with most rural communities, the RHCM network of centers serves a poor population. Within this network, a total of 50 percent of the population has an income less than 200 percent of Federal poverty guidelines. Some of the areas, such as Eastport, where 80 percent of the population has an income below 200 percent of poverty.

Within the population served by the network of health centers, there are approximately 5,000 individuals 65 years of age. These individuals are primary users of health center services, and new and ancillary service development is often targeted to meet their specific needs.

Health centers are committed to the concept of maintaining an individual in their own home as long as possible. All of the centers in RHCM network have identified a need for increased home-based care.

One of the major obstacles to care for elderly patients is their ability to coordinate and arrange for a variety of services they need. While federally funded health centers are mandated to provide coordination of care through case management, funding has not been provided to staff this function. Case management could, ideally, be provided by social workers. There are none within the staffing configuration of this network of centers. Case managers could provide a vitally important service to the elderly. In fact, to all our patients.

Care provided by multiple providers and agencies need to be coordinated at one central point. Otherwise, aspects of care may fall between the cracks; be avoided due to transportation, scheduling, or financial issues; or, in some instances, even duplicated. Case management could solve these problems.

In summary, we ask your attention and support of the following issues to help health centers reach their potential in providing maximum access to elderly and rural patients: continue the Public Health Service funding for community health centers; support of manpower training and placement programs; support of funding for case management workers in health centers; support for expansion of home health delivery methods.

Thank you.

[The prepared statement of Ms. Lane follows:]

RURAL HEALTH CENTERS OF MAINE, INC.
3 Commercial Street
Augusta, Maine 04330

TESTIMONY

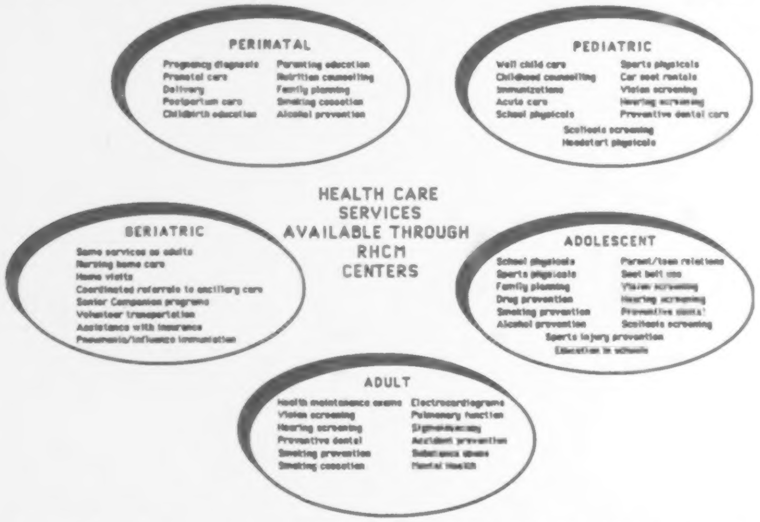
September 18, 1989 - 10:00 A.M. - Bangor House

HEALTH CARE FOR THE RURAL ELDERLY: INNOVATIVE APPROACHES TO PROVIDING COMMUNITY SERVICES AND CARE

Rural Health Centers of Maine, Inc. (RHCM), is a network consisting of a central administrative office and seven rural community health centers in the following Maine communities:

- Aroostook Valley Health Center (AVHC) - Ashland
- Arthur Jewell Community Health Center (AJCHC) - Brooks
- D.F.D. Russell Medical Center (DFDR) - Leeds
- East Grand Health Center (EGHC) - Danforth
- Eastport Health Care (EHC) - Eastport
- Harrington Family Health Center (HFHC) - Harrington
- Katahdin Valley Health Center (KVHC) - Patten

This network of centers serves a population of over 41,000 people, living in 54 communities. All seven centers face a demand for primary care which exceeds the total available supply of services. As the primary source of care in its service area, each center faces the charge of attempting to provide or coordinate all care to all people. In order to meet this charge, the scope of services provided by the centers has grown and needs to expand even further. Currently, the centers are offering primary and ancillary services as summarized in the following chart:


HEALTH CARE SERVICES AVAILABLE THROUGH RHCM CENTERS
PERINATAL
Pregnancy diagnosis
Prenatal care
Delivery
Postpartum care
Childbirth education
Parenting education
Nutrition counselling
Family planning
Smoking cessation
Alcohol prevention
PEDIATRIC
Well child care
Childhood counselling
Immunizations
Acute care
School physicals
Sports physicals
Car seat rentals
Vision screening
Hearing screening
Preventive dental care
Scoliosis screening
Headstart physicals
GERIATRIC
Same services as adults
Nursing home care
Home visits
Coordinated referrals to ancillary care
Senior Companion programs
Volunteer transportation
Assistance with insurance
Pneumonia/influenza immunization
ADOLESCENT
School physicals
Sports physicals
Family planning
Drug prevention
Smoking prevention
Alcohol prevention
Parent/teen relations
Seat belt use
Vision screening
Hearing screening
Preventive dental
Scoliosis screening
Sports injury prevention
Education in schools
ADULT
Health maintenance exams
Vision screening
Hearing screening
Preventive dental
Smoking prevention
Smoking cessation
Electrocardiograms
Pulmonary function
Sigmoidoscopy
Accident prevention
Substance abuse
Mental Health

Each of the seven centers is located in an isolated, rural area of the state designated as a medically underserved area. Most travel to receive any medical care in these areas is over secondary roads and is additionally hampered by the extreme winter weather conditions. Primary hospital care is provided by small rural hospitals, all of which are facing increasing obstacles to continued functioning. The average distance between a center and a tertiary care hospital is 92 miles, with an extreme of 150 miles. The isolation of these areas is shown in the map on the following page.

Each center stresses family-oriented, preventive care, where health promotion and disease prevention activities are offered as ongoing aspects of individual care and organized community events. The centers are staffed by 12 physicians and eight mid-level practitioners, each of whom is a board-certified practitioner.

Retention of provider staff is difficult in these areas, where personal and professional isolation is so severe. In just this year, 10 of the 20 providers are new. In order to serve these communities, providers give up much of their personal time—a strain contributing to the high burn-out and turnover rates. Providers need to be available 24-hours a day. This after-hours coverage is shared between the small provider staffs —usually two-to-three per center. Unlike their peers in larger communities, this responsibility cannot be spread out among a group of providers. Coverage of hospitalized patients is difficult, given the time required to travel to and from distant hospitals. Individual incomes are lower for rural providers than for their urban peers. The sparse populations, coupled with high rates of poverty, do not afford the possibility for higher incomes. Even though all of these centers receive Public Health Service funding to partially support provider salaries, these funds are limited and do not increase proportionally to cost of living increases and the need to remain competitive with urban practice opportunities.

While all of these factors lead to high provider turn-over, they are also deterrents to recruitment. In the past, professionals have been available for assignment to these areas through the National Health Service Corps. Even with the NHSC, some centers have undertaken recruitment campaigns which have required in excess of a year to result in hiring. This year, there will be fewer than 200 professionals available nationally through this program. Alternatives to the NHSC, such as the loan repayment program, are not yet proving to be functional options. Only a very few inquiries have been forthcoming from providers seeking placement in a loan repayment area, and, as of yet, no successful placements have occurred as a result of this program.

Coupled with the loss of the NHSC, rural communities are suffering from the results of the erroneous studies of several years ago which predicted a surplus of physicians, resulting in decreased support for educational programs. This surplus of physicians is not being realized in primary care, and certainly not in rural communities. One national recruitment firm has estimated that, currently, there are 10,000-15,000 family practitioners being recruited. Residency programs are graduating 1,600 of these physicians annually to fill this need. Less attractive, rural areas will not be able to compete in this environment.

Equal to the need for physicians is the need for mid-level practitioners. These professionals have consistently been proven to be a cost-effective option for providing primary care. They generally have had better retention rates in rural health centers than physicians. They are welcomed in the communities and are very well received by patients. However, they have become very scarce. Enrollment in training programs is declining, and the available pool of mid-level practitioners is experiencing greatly expanded employment opportunities. Health centers must now compete with many hospitals, Health Maintenance Organizations, and urgent care centers to recruit mid-level practitioners. These urban facilities are able to offer working conditions and salaries which are far more attractive than those available in rural areas. Not only is the manpower pool becoming more scarce, reducing the center's ability to provide needed services, the inability to recruit mid-level practitioners has drastic financial effects for the practices.

All seven of these centers are certified rural health clinics, receiving reimbursement for Medicare and Medicaid services, on a cost basis. This program provides a vital revenue stream to rural health centers, without which services would be drastically reduced. As certified rural health clinics, centers are required to have either a physician assistant or a nurse practitioner on staff 60% of patient care time. While recently proposed changes to the Rural Health Clinics Act reduces this requirement to 50%, this reduction hardly impacts rural health centers. Several centers, during the past year, have faced the loss of their rural health clinic status due to the time required to recruit mid-level practitioners. This situation creates a double jeopardy of loss of manpower and loss of a vital reimbursement system.

We urge consideration of any and all efforts to address the health manpower shortages facing rural American today. Without manpower, services will decrease. Less care will be delivered early in an illness. Acute care will increase. Decreased manpower will eventually lead to sicker people cared for in more intensive care settings, resulting in huge increases in medical costs.

As with most rural communities, the RHCM network of centers serves a poor population. Within this network, a total of 50% of the population has an income less that 200% of federal poverty guidelines. Some of the areas have extremes of this total, such as Eastport where 80% of the population has an income below 200% of poverty. Public Health Service funding allows rural health centers to offer sliding fee scales to patients who otherwise could not afford care. However, these funds are decreasing each year, making it more difficult to continue this support to poor patients.

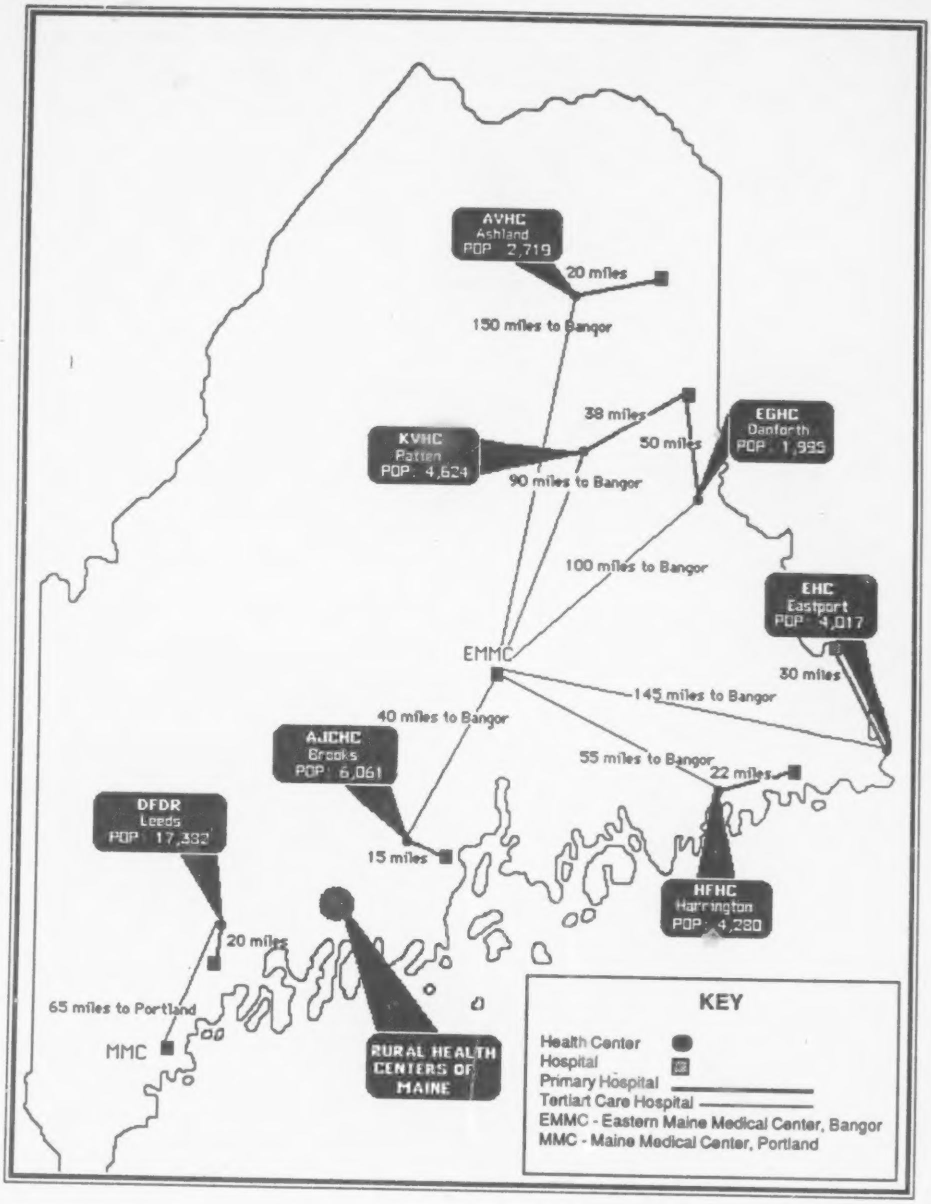
Within the population served by the network of health centers, there are approximately 5,000 individuals over the age of 65. These individuals are primary users of health center services, and new and ancillary service development is often targeted to meet their specific needs. Special education sessions are offered in heart disease, diabetes, Alzheimer's disease, and arthritis. Four of the centers are able to provide podiatry services. Six centers provide medical coverage to 11 nursing homes. All centers are willing to provide home visits. Health centers are committed to the concept of maintaining an individual in their own home as long as possible. All of the centers in the RHCM network have identified a need for increased home-based care. While all of the centers work closely with area home health agencies, often these staffs are limited and must serve a very broad geographic area. The Maine State Bureau of Medical Services has recently proposed that home-based care delivered by RN's and LPN's be added to those services which can be reimbursed by Medicaid in Maine rural health clinics. In order for these services to be reimbursable, the center must be designated as a home health care shortage area. While this proposal is so new that health centers have not yet had the opportunity to become familiar with the designation criteria, they look forward to being able to provide this much needed service in all service areas and would like to be able to meet this need for all homebound patients, rather than just those covered by Medicaid, particularly since the needs of the elderly population are increasing.

One of the major obstacles to care for elderly patients is their ability to coordinate and arrange for the variety of services they need. While federally-funded health centers are mandated to provide coordination of care through case management, funding has not been provided to staff this function. Case management could, ideally, be provided by social workers. There are none within the staffing configurations of this network of centers. Case managers could provide a vitally important service to elderly, in fact, all patients. Care provided by multiple providers and agencies needs to be coordinated at one central point. Otherwise, aspects of care may "fall between the cracks;" be avoided due to transportation, scheduling, or financial issues; or, in some instances, even duplicated. Case management could solve these problems. Case managers located in a health center could provide the following needed services:

- Coordination of care provided by multiple providers and agencies
- Assistance with scheduling and transportation needs to obtain care
- Identification of resources available to provide needed services
- Assistance with Medicare billing issues which are, more and more, a complication that is extremely difficult for elderly patients to deal with
- Expanded patient education activities and follow up to assure patients are receiving the instruction they need
- Early identification of discreet problems which may not be obvious in the acute care setting, such as substance abuse or mental health problems
- Clinical counselling
- Follow up and tracking to assure patients are receiving all the care they need

In summary, we ask for your attention and support of the following issues to help health centers reach their potential in providing maximum access to elderly and, indeed, all rural patients:

- Continued Public Health Service funding for community health centers
- Support of manpower training and placement programs
- Support of funding for case management workers in health centers
- Support for expansion of home health delivery methods


AVHC
Ashland
POP 2,719
20 miles
150 miles to Bangor
38 miles
EGHC
Danforth
POP 1,995
50 miles
KVHC
Patten
POP 4,624
90 miles to Bangor
100 miles to Bangor
EHC
Eastport
POP 4,017
EMMC
30 miles
145 miles to Bangor
40 miles to Bangor
AJCHC
Brooks
POP 6,061
55 miles to Bangor
22 miles
DFDR
Leeds
POP 17,332
15 miles
HFHC
Harrington
POP 4,280
20 miles
65 miles to Portland
MMC
RURAL HEALTH CENTERS OF MAINE
KEY
Health Center ●
Hospital ▨
Primary Hospital
Tertiart Care Hospital
EMMC - Eastern Maine Medical Center, Bangor
MMC - Maine Medical Center, Portland

Representative **Snowe**. Thank you, Ruth.
Dr. Power.

STATEMENT OF HILTON POWER, ED.D., VICE CHAIR, MAINE COMMITTEE ON AGING, AUGUSTA, ME

Mr. **Power**. Good afternoon. Thank you very much for this opportunity.

My name is Hilton Power, and I am the vice chairman of the Maine Committee on Aging.

In view of all that has gone before, I really could just fold up my tent and leave. Having got something in mind, I am determined to at least give you the highlights. I left a lot of things out that have already been said before, so I will jump right into it.

While it may be conceded that because of Medicare seniors have better access to primary and hospital care than do the general population, this may not be so for the subset of rural elderly people living in Maine. The major barriers standing in the way of older people accessing health care in Maine are lack of transportation and out-of-pocket costs. We have heard that before, but I think it is the most important thing, probably, that has come out of it.

Transportation is one of the most pressing unaddressed problems for rural Maine seniors. In Maine today, 79 percent of people age 65 or older live in towns of less than 10,000, where there is no ongoing regular public transportation. Couple this with the fact that 34 percent of Maine seniors never had or have given up their drivers' licenses. Given this, clearly, seniors in rural areas have great difficulty getting to medical services.

I am told a number of old people in Maine, who in addition to the transportation issue just mentioned, simply do not seek needed health care services because of unknown out-of-pocket costs. This has been alluded to already. Medicare beneficiaries now spend about 15 percent of their income on medical care. Out-of-pocket health care costs such as deductibles, coinsurance, balance billing, and the cost of preventive care pose special problems for the elderly poor and near poor, especially those not eligible for Medicaid.

A recent HCFA study found that out-of-pocket expenses as a percentage of income were six times greater for poor and near poor people than for their middle income counterparts.

I think we have come to this question about regulations, and so on, and how they are interpreted and enforced, and the question of flexibility. Here is something that I think is also interesting. Even though many who are covered by Medicare have problems with access, those who are not eligible for Medicare or cannot afford private insurance have critical access problems. We estimate that 2 to 3 percent of Maine's elders are not covered by Medicare.

There is also a group we call the Medicare wives. These are women whose husbands retire with Medicare, yet their wives are not yet eligible because they are younger. They then apply for private insurance, yet often are told they must wait 3 years for coverage due to preexisting health conditions.

They call the Maine Committee on Aging in a panic because they find themselves in the stressful situation of being 62 years old, 3 years away from Medicare and uninsured for the first time in their lives. So it seems that something could be done. These people can afford private insurance—but they cannot obtain it at any price and cannot qualify for Medicaid. Access to health care for these spouses is very limited.

The final comment we would like to make is to raise quality and access issues. One of the most frustrating problems facing us is the issue of older people who need nursing home care but are backed up in hospitals. This has been mentioned before, but I have some statistics.

In April 1989, the Society of Hospitals Social Workers, at the Maine Committee on Aging's request, and with the assistance of the Maine Hospital Association, conducted a 1-day survey "snapshot" for the "days awaiting placement" patients in Maine hospitals. They found that on April 14, 1989, 201 people were inappropriately backed up in Maine hospitals for a total of 25,205 days because there were not enough home care resources and heavy care beds in the community. Not only is this hospital care inappropriate because patients are not getting the rehabilitation and social services in a hospital that they would get in a nursing home or at home, but it is also more expensive both to payers and consumers.

That is all.

[The prepared statement of Mr. Power follows:]

MAINE COMMITTEE ON AGING
State House Station 127
Augusta, Maine 04333

LOCAL [illegible]
TOLL FREE 1-800-452-1912
(for Ombudsman Program)

GOVERNOR
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Rep. David Hickey
Dorothy [illegible]
James [illegible]
Hilton Power
George Pray

September 14, 1989

Comments of Hilton Power, Vice Chair of the Maine Committee on Aging at the Joint Field Hearing of the House Select Committee on Aging "Health Care for the Rural Elderly: Innovative Approaches to Providing Community Services and Care."

TO: Congresswoman Olympia Snowe
Senator William Cohen

Good morning, I am Hilton Power, Vice Chair of the Maine Committee on Aging, a 15-member citizens advisory group in Maine mandated to advise the Governor and the Legislature concerning issues that affect Maine's older citizens.

As you well know, older people have more chronic conditions than any other age group and thus are heavier users of our health care system. On average seniors visit a physician 6 times for every 5 visits by the general population. They are hospitalized approximately twice as often, stay twice as long and use twice as many prescription drugs.

While it may be conceded that because of Medicare, seniors have better access to primary and hospital care than do the general population, this may not be so for the subset of rural elderly living in Maine. The major barriers standing in the way for older people accessing health care in Maine are lack of transportation and out-of-pocket costs.

As Congresswoman Snowe is keenly aware, transportation is one of the most pressing unaddressed problems for rural Maine seniors. In Maine today, 79% of people age 65 or older live in towns of less than 10,000, where there is no ongoing regular public transportation. Couple this with the fact that 34% of Maine seniors never had or have given up their drivers' licenses and it is clear that seniors in rural areas have a very difficult time getting/to medical appointments especially with specialists who are only located in the major cities.

The advent of day surgery has also made services more difficult for Maine seniors to obtain. For example, a lot of planning must take place in order for Mrs. Smith from Sherman Station to get to Eastern Maine Medical Center in Bangor 80 miles away, for 7:00 a.m. day surgery. It is even more complicated to get her back home again. Included in that planning are budgeting for the out-of-pocket costs for lodging and meals. Ten years ago, Mrs. Smith would have entered the hospital for a 2 day stay for which Medicare would have paid. Today the prospect of day surgery presents a whole milieu of new problems. Take also the dilemma of Mrs. Jones who lives in Madawaska who needs daily radiation treatment after breast surgery. Without transportation to a chemotherapy site it is impossible for her to get this needed follow-up care.

Clearly, there are untold numbers of older people in Maine who in addition to the transportation issue just mentioned simply do not seek needed health care services because of unknown out-of-pocket costs. Medicare beneficiaries now spend about 15% of their incomes on medical care. Out-of-pocket health care costs such as deductibles, co-insurance, balance billing and the cost of preventive care pose special problems for the elderly poor and near poor especially those not eligible for Medicaid. A recent HCFA study found that out-of-pocket expenses as a percentage of income were 6 times greater for poor and near poor people than for their middle income counterparts. Only one-fourth of the elderly poor and near poor are protected by Medicaid. What this means is that older people unsure of what their out-of-pocket health care expenses will be, but knowing they cannot pay them will often do without needed care rather than risk nonpayment. Clearly this is not solely an issue facing older people in rural areas, but it continues to be one of the major stumbling blocks for access to care.

Even though many who are covered by Medicare have problems with access - those who are not eligible for Medicare or cannot afford private insurance have critical access problems. We estimate that 2-3% of Maine's elders are not covered by Medicare. There is also a group we call the "Medicare wives." These are women whose husbands retire with Medicare, yet their wives are not yet eligible because they are younger. They then apply for private insurance, yet often are told they must wait 3 years for coverage due to pre-existing health conditions. They call the Maine Committee on Aging in a panic because they find themselves in the stressful situation of being 62 years old, 3 years away from Medicare and uninsured for first time in their lives. While there are not an overwhelming number of "Medicare wives", these women are caught between systems. They often can afford private insurance but cannot obtain it at any price, and cannot qualify for Medicaid. Access to health care for these spouses is very limited.

The final comment we would like to make is to raise a quality and access issue. One of the most frustrating problems facing us is the issue of older people who need nursing home care, but are backed up in hospitals, because of the lack of community-based services. In April, 1989, the Society of Hospitals Social Workers, at the MCoA's request and with the assistance of the Maine Hospital Association conducted a one day survey "snapshot" of the "days awaiting placement" patients in Maine hospitals. They found that on April 14, 1989, 201 people were inappropriately backed up in Maine hospitals for total of 25,205 days because there weren't enough home care resources and heavy care beds in the community. Not only is this hospital care inappropriate because patients are not getting the rehabilitation and social services in a hospital that they would get in a nursing home or at home, but it is also more expensive both to payors and consumers.

This is not a Maine specific problem but rather a quality of care and access issue we must address on a national level. Access issues for older people remain most critical, not in the acute and primary care settings, but rather in the long term care settings.

We appreciate the opportunity to share our comments with you. Thank you.

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Representative SNOWE. Thank you all very much. I think that what you all said reflects exactly what we need to do, and that is to have a networking take place among the agencies, communities, rural health centers, providers, and hospitals. This kind of partnership can help address some of the problems of the changing, health care environment.

I know you understand that a significant change has to occur in our current delivery system, given all the changes and demands of rural health care.

Nona, you have had a national role in the Rural Health Care Association. Can you tell me, are the rural health care problems that we in Maine face any different than those faced by rural areas in other parts of the country?

Ms. BOYINK. I do not think they are significantly different. I think we found, as NRHA has worked on issues, that in many ways, the problems in Maine are not—I hate to say not quite as bad, because I do not want the attention to drop—but we do have a good record of cooperation. We have a strong system of hospitals. Look at Maine and look at Texas. We have lost only two hospitals. We have 23 community health centers for a million people.

But overall, the kinds of problems, the lack of transportation, lack of physicians and other health care professionals is at least as bad in Maine. We have been heavily dependent on the National Health Service Corps and the demise—essentially the demise, of the National Service Corps has left many of us in situations where we have been recruiting for 2, 3, 4 years for a single position. We at KVRHA currently have three vacancies in our community health centers. That is not uncommon in the other rural areas of the country.

So I think that there are many solutions that can be national solutions that Congress can work on that will benefit a lot of people. Many of the solutions that are appropriate in other areas can be helpful here, particularly, the networking, emphasis on making sure that rural hospitals, community health centers, Area Agencies on Aging, all work together on these problems.

Representative SNOWE. Do you believe it is happening now? I know that to some extent it is, but could there be a lot more done in this respect?

Ms. BOYINK. I think a lot of that revolves around the reimbursement.

Representative SNOWE. Medicare reimbursement?

Ms. BOYINK. It is just not flexible.

Representative SNOWE. For home health care service?

Ms. BOYINK. For home health care services. As Ruth pointed out, for case management services. I mean, rural health centers are mandated under the Public Health Service statutes to provide case management. We are not funded to do it. Nobody else—none of the third-party payers pay for it.

Representative SNOWE. You are required to provide case management?

Ms. BOYINK. It is a mandatory service.

Representative SNOWE. But you are not reimbursed?

Ms. BOYINK. Right.

Representative SNOWE. Case management makes a lot of sense.

Ms. Boyink. Particularly in rural communities where you can combine it.

Representative **Snowe.** Absolutely. So is this service provided—do you have to provide this service in any event?

Ms. Lane. We do not provide it. We do not have the funds to pay for case managers.

Ms. Boyink. What happens in actuality, the way you meet the requirement, is that the physicians and sometimes the nurses end up doing the case management, in the individual community health centers.

Now, you look at the productivity of rural physicians and rural mid-level practitioners, and in order to make ends meet, they need to see just as many patients, if not more, than their urban counterparts, and yet they don't have the vast array of services or case managers or other people available to them to help them do that.

Representative **Snowe.** So a lot of people inevitably would fall through the cracks?

Ms. Boyink. Right.

Representative **Snowe.** I mean, given that, and the transportation probelms you cited, Chris, a person who has to come down for day surgery because he cannot stay overnight in the hospital as it is not reimbursed under Medicare, he has to come back from Aroostook County to Eastern Maine Medical Center the next day for follow up care. That is the kind of difficulty many people face in trying to get any kind of medical attention.

What can we do—beyond Medicare reimbursement, and home health care which has been mentioned—what else?—transportation.

Ms. Boyink. The transportation, as you discovered on your recent tour of the State. That is an absolutely critical, critical piece.

Representative **Snowe.** Absolutely.

Ms. Boyink. We end up—we had an interesting example when we were talking with Senator Cohen's staff, of a patient at the Western Maine Health Center who needed specialty follow-up care for two different problems that had to take place in Portland. This person, fortunately, had a spouse at home to try to help arrange that, but they had to make trips 5 different days to Portland from a little tiny town outside of Livermore Falls to try and get all these pieces put together. She had to scramble around and find people to take her because she could not drive and there was no transportation system there to do that.

Ms. Gianopoulos. We offer—the State Medicaid program does reimburse for transportation. But once again, we have a situation where we are able to serve a very small proportion of older people. I think something like 15 percent of older people in Maine are qualified for Medicaid. That leaves another 85 percent whose transportation costs have to come out-of-pocket.

I was talking to someone the other day who was telling me it costs $25 each way to go from Biddeford to Portland for radiation. If you have to pay for private transportation, if you do not qualify for low income transportation, it is $50 round trip from Biddeford to Portland. Most people—not to mention older people—do not have that kind of discretionary income.

Representative **Snowe**. Dr. Power, you mentioned in your testimony, this inappropriate placement of a number of individuals in hospitals because of the lack of nursing home beds. What about the concept of swing beds? I think there are only about two hospitals in Maine, two rural hospitals, that have instituted the swing bed concept. Is this an idea that we ought to pursue?

Mr. **Power**. I think the real bank is the community-based services, you know. That and the transportation would make the solution.

But the swing bed thing is one way of doing it. As you say, there are a couple—I am not sure how many—but there are some hospitals that have them, and I think they are obviously——

Ms. **Gianopoulos**. But Medicare will have to reimburse at a rate as the gentlemen from—hospitals lose money on skilled nursing facility beds. It has got to be—you have to at least break even for them to consider doing it.

Representative **Snowe**. Brian, do you want to come forward?

Senator **Cohen**. I think perhaps you ought to have an opportunity to make some remarks before we put any more questions.

STATEMENT OF BRIAN RINES, MAINE CITIZENS FOR QUALITY HEALTH CARE

Mr. **Rines**. I appreciate the opportunity.

I am Brian Rines, and I think you have printed copies of my remarks. I am here representing the Maine Citizens for Quality Health Care, which as both of you may know, is an organization that the trustee advisory group of the Maine hospital family put together last spring. We solicited throughout Maine for membership and had more than 7,500 people volunteer to join our organization, interested in fostering better health care in the most comprehensive sense for the citizenry of Maine.

It is a honor for me to be here today.

As you may know, we are interested in basically ensuring that a grass roots work and grass roots involvement in the development of health care policy involve as many people as possible throughout the State, and that those messages get to our legislators, and as we have already done in Washington and speak to you also.

As I hope you have heard today, a tremendous concern to those of us in the community is a need for flexibility in resources, and at least speaking as a hospital trustee, ensuring that a continuation of a reasonable range of Medicare funding is incredibly important.

We received some relief this year from the State legislature in terms of our Medicaid shortfall, but it is not even beginning to touch the overall needs of health care needs, especially of an elderly population in a State like Maine.

In fact, I heard a radio interview driving up here that cited you all as talking of the shortage of Maine physicians. We all have had the experience, at least in the hospital family, of seeing a hospital cut back on services or close, at which point valuable personal resources that are really part of the hospital, that really make that hospital up, then begin to leave town or transfer their practices out of that community, which diminishes the range, the whole range and quality of the health care services that are available.

I think that those of us in Maine are especially fortunate to have rural health care advocates, as you two. We commend you, Senator Cohen, for your support of the Medicare resolution and certainly thank Olympia for the deep concern and special interest in this issue.

Another problem that really is part of the whole issue is that hospitals and rural hospitals—and I presume this is true across the country, but certainly true in a rural and not very wealthy State as Maine—have very little in the bank. I mean, it is not as if we are sitting on huge endowments of lots of corporate support, because this still remains one of the poorest—at least in terms of financial measures—States in the country. So when somebody falls behind in paying their bills, this Medicare has done so tremendously over the last few years, the ripple effect is far beyond its mathematical weight and is crushing to Maine hospitals.

We are intensely concerned about having the quality care diminish even more. I know both of you have heard—and I can tell you from my own family—stories of folks who have to go great, great distances for medical care, which disrupts the whole family, disrupts the treatment plan, and the literature I think will tell you, will also impede recovery when the social and personal supports are not available to patients, particularly frailer patients who are recovering from very important and also very strenuous surgeries.

Another element that always involves our communities—I have a line in my statement that I think sums it up—most of us know that the only light that is shining in town at 3 a.m., the only light that is available out of the thousand points of light that might be available during the day, is the emergency room. As hospitals diminish, as hospitals lose their ability to respond, these lights are going to get dimmer and dimmer. They may still stay well-lit here in Bangor and Augusta and Waterville and Portland, but we have to be concerned about another 28 or so or 30 hospitals that are scattered in small communities throughout.

One other point I heard this morning as I was driving up here was the shortage of providers in—Aroostook was specifically mentioned and physicians were specifically mentioned, but other bodies of health care professionals are seeking provider status under Medicare.

I happen to belong to one of those professions, but family health practitioners, psychologists, and clinical social workers who provide very needed outpatient health and mental health services could be available to elders at a significantly reduced cost of what the inpatient care is today, whereas extenders to physicians at a great enhancement in the community and a reduced financial impact.

I want to thank you for giving me the opportunity to sneak in here late. We are incredibly concerned about the quality of life in Maine. I mean, that is why most of us are here. We are incredibly concerned that the health care status, that it does not continue to degrade, and I cannot think anybody in this room can tell you that things are as well off as they were 10 years ago, and that the people who are the essential element of the health care services, whether they are physicians or nurses or nurse extenders, are desperately needed to stay in Maine. The only way we are going to do that is to build a comprehensive system of care that not only includes super-duper high tech hospitals, but community hospitals and nursing home care and home health care and in-patient/outpatient mental health services, and we cannot do that on the cheap.

I had one, kind of nasty, line in here that basically says, our trustees want you to remember that we are terribly interested in our "elected officials who devote phenomenal amounts of time and energy to bailing out the savings and loan industry, or debating how many Stealth bombers our Nation needs to counter the Soviet threat, are terribly out of touch with what the people of Maine need."

As you may know, we rebuilt our hospital in the last 10 years, and at the time we were doing it, as a blue sky exercise, we asked our architects to tell us what kind of Kennebec medical center in Augusta could be recreated for. They told us then, 10 years ago, $45 million. It boggles my imagination that we could build a dozen of my hospitals, or the hospital that I serve, for the price of one of these planes.

But put it the other way around, how can we imagine spending that kind of money for one piece of weaponry, when we could build a dozen hospitals, Lord knows how many nursing homes, would provide how many of those psychiatrists or rheumatologists that are lacking in Aroostook County.

I hope that our hearing today is a productive one, and I thank you again for the opportunity to be here and have a chance to speak.

[The prepared statement of Mr. Rines follows:]

Proposed Testimony

Joint Hearing
House and Senate Committees on Aging
Bangor, Maine

September 18, 1989

Maine Citizens For Quality Health Care

Senator Cohen. Representative Snowe. My name is Brian Rines. I am a resident of South Gardiner, a psychologist in private practice in Augusta and chairman of the both the Kennbec Valley Medical Center in Augusta and Maine's statewide hospital Trustee organization.

It's a great honor today for me to speak on behalf of yet another group with which I'm involved---**Maine Citizens For Quality Health Care**, a nonpartisan statewide organization established earlier this year to help educate Maine people about important health care issues and get citizens involved in developing solutions to health care-related problems.

Maine Citizens For Quality Health Care, which now numbers well over 7,000 people from throughout Maine, is chaired by former Governor Ken Curtis, a Trustee at Eastern Maine Medical Center here in Bangor, and Richard Morrell, a business leader and former state senator from Brunswick who serves on the board of Mid-Coast Health Services in that community.

The **goals** of **Maine Citizens For Quality Health Care** are simple:

•To serve as a strong voice representing the interests of ordinary Maine citizens in the development of health care public policy

•To support efforts to make quality health care available and affordable to as many Maine people as possible, regardless of where they live or their ability to pay for that care

•To ensure our community hospitals have the flexibility and resources necessary to respond to the changing health care needs of the people we serve.

As you've already heard from Ted LaLiberty of the Maine Hospital Association, it's getting harder and harder for our small, rural hospitals to meet the needs of the people we serve. Too often---in Maine and across the rest of the country---the small, rural hospital is forced to close its doors because of mounting financial pressures. This is of special concern to the nearly 1,000 men and women who represent their communities as volunteers on hospital boards here in Maine. That is one of the reasons our Trustees decided to form **Maine Citizens For Quality Health Care**---to inform the people of Maine about the uncertain future of hospitals serving small, sometimes isolated communities, and to ask their help in making sure elected officials understand how essential our hospitals are to our communities.

I must say Maine is fortunate in that we have strong rural health care advocates in you, Senator Cohen and Representative Snowe. I commend you, Senator Cohen, for your noteworthy support of rural health care, including your signing of a Congressional resolution last February calling for an end to the disproportionate cuts to Medicare that are hurting our rural hospitals. I also want to thank Rep. Snowe for your deep concern and special interest in this issue.

Hospital Trustees have the tremendous responsibility of ensuring the health care needs of our communities are being met. We take this responsibility very, very seriously. We also have the responsibility of ensuring our hospitals are well managed in a financial sense.

We understand, perhaps better than anyone else, what is at stake when a small community loses its access to hospital care. We understand this because many Trustees still active on their boards, remember a time not so very long ago when hospital care did not exist in their community. These Trustees often were involved in pulling their communities together in support of building a hospital, planning the facility, raising the necessary funding and building and staffing the local hospital. Trustees have dedicated hundreds, even thousands, of hours of volunteer time "growing" their local hospital literally from the ground up. They have a tremendous personal investment in their community hospital and an equally intense commitment to making sure the hospital is indeed providing quality care to the community.

Many of our small,. rural hospitals have little more in terms of resources than this commitment by Trustees and others in the community. They do not have sizeable endowments or corporate support. They don't have a fat bank account to fall back on during lean times. During good times, most of our hospitals re-invested any profits they made back into the hospital to buy more up to date medical equipment and technology, to hire health care professionals with special skills and to expand services to meet the ever-changing needs of their communities.

Because, as Trustees, our lives our bound up in our hospitals, we understand more than others how dependent our friends and neighbors and local businesses are on our hospitals. We know, for example, that when our community is attempting to attract a business to the area that will provide more jobs, the availability of health care is extremely important. We understand the strains placed on families, often dependent on two or three jobs to make ends meet, when they have to travel long distances to be with a son or daughter or mother or father who's been hospitalized far away because care wasn't available close by. We know that when a hospital closes in a rural community, physicians frequently leave the area to be closer to a hospital, that businesses often will relocate to a town where care is more available and perhaps most importantly, people who need care the most will go without that care and suffer alone. Our Trustees remember what it was like when a friend or family member seriously injured in an accident simply could not get care because there were no 24-hour emergency care services available.. Our Trustees know hospitals are the very backbone of Maine's emergency care system. We know that the light in the emergency room very well may be the only light shining in town at 3 a.m. when a serious care accident occurs.

Earlier this year, for the first time on an organized basis, Trustees and other concerned Maine citizens began talking with community groups, the media and elected officials about the increasingly desperate financial shape in which our hospitals are operating. The response has been astounding. Thousands of people have come forward to express their concern by joining **Maine Citizens For Quality Health Care.** They told us---and continue to tell us---that preserving access to health care is an *extremely* high priority. They tell us that elected officials who devote phenonomal amounts of time and energy to bailing out the S&L industry or debating how many Stealth bombers our nation needs to counter the Soviet threat are terribly out of touch with what they want. There is absolutely no question that what Maine people want is access to quality health care as close to home as possible. Given this, we believe it's time for Congress to devote more attention to honoring its commitment to fully funding Medicare and to do everything possible to assure access to care, especially in rural areas, is broadened---not jeopardized---by federal policies. This means Medicare must be directed to pay our hospitals at least what it actually costs to provide care to our elderly citizens. This means that the federal government must end the practice of reimbursing rural hospitals less than urban hospitals for care provided to Medicare patients. This means the government must assist hospitals that cannot or should not survive as acute care institutions transition to long term care or other facilities that best meet their communities' needs. This means the Congress should approve the extension of Medicare provider status to nurse practitioners, licensed clinical social workers, psychologists and others, allowing funding for outpatient care for diverted or discharged patients. And finally, this means that the federal government must recognize that a exceptionally serious and growing shortage of health care professionals, particularly in rural areas, demands immediate attention or access to care will be denied to many people simply because hospitals and other agencies simply will not have the trained people to care for those of us living in rural areas. We urge you to recognize the health care human resources shortage as the crisis that it is and to aggressively support increased scholarships, loan forgiveness programs and other incentives to recruit and retain caregivers without whom our health care system will perish.

It's all a matter of recognizing the priorities of real people, not the lobbyists that walk the halls of Congress and have the money for honoraria. The single message I want to leave with you today is there is no question what the people of Maine consider important. It is very simple. They want to be certain that quality health care is available when they need it. Our hospitals were built with that single mission in mind. So we must do everything in our power to stop government practices that are preventing our hospitals from providing the care our rural communities so badly want and need.

Thank you very much.

Senator **Cohen**. I will thank all of the witnesses who have come here.

I must tell you, I do not know whether it makes sense to have a total restructuring of the system. As I, over the years, have studied this, I am amazed at the confusion that exists within the health care system itself. I mean, if I were an ordinary citizen who was suddenly confronted with a medical problem, I would probably send a letter to Olympia saying, "Explain this to me. I've got Medicare here or Medicaid there, or it is reimbursable if I stay so many days here but not if I go into a nursing home, and by the way, the home health care benefit doesn't cover the following." I would say, "Who is there to explain this to me?"

We have been talking here about a case manager, but there is not a single social worker in any of the health centers, is there? Not one.

Ms. **Lane**. No. The doctors are doing the case management work.

Senator **Cohen**. Theoretically, I would assume that it would probably be an ideal, or at least a more ideal system, to have a single entry system where a person comes to a single center and we say, "Here are the services that are available. Here is what is covered and this is what you should do. This is the level of care we think you need and this will be the follow-up care once you have the surgery or the cataract operation that is necessary." Ideally we could have some single point in which a person can get this information.

But it must be absolutely a blizzard of confusion for most people. I assume that this also accounts for why the elderly often do not seek treatment.

Ms. **Gianopoulos**. We have a case management system through the Area Agencies on Aging, but the problem is we may serve 3,000 to 4,000 older people a year, and if you look at the discharge figures, probably 50,000 older people are discharged from hospitals from Maine.

So, yes, we have the service, but we are barely meeting the need.

Ms. **Boyink**. That really only connects with people, for the most part, when they are discharged from the hospital, so trying to get them into the system earlier to perhaps keep them out of the hospital in the first place, becomes particularly difficult.

Mr. **Rines**. You are right on the button. If you look at people trying to imagine what health care is going to be like in the United States 20 years from now and what role hospitals are going to play, they describe the system exactly as you just did, Senator, where there is a central core of available health care and social service people who do initial assessments and then ensure that through the case management and through ombudsman type people, that the kind of care that somebody needs, an individually tailored treatment plan; is developed and that person is followed or pushed through that system to ensure they get what they need. It is like you are reading our plan documents.

Senator **Cohen**. I have been looking at this for some years now, and it still is as confusing as ever. It seems that every time we change one aspect, it is sort of patchwork, it causes a distortion elsewhere.

Of course, we hear from time to time the need perhaps to have a plan based upon that of Canada or Britain or some other country in which they have either a socialized medicine or national health insurance program. Obviously, there are probably some assets in those programs, but also some liabilities as well. I think it is probably because we do not have a major focal point, that single entry level, or office that can make not only the administrative diagnosis, but also have the follow up that is necessary to make sure that a person does not stay in a hospital, or get shuffled off to a nursing home, who could be better served at home with a modest amount of care on a bi- or tri-weekly basis.

I want to thank a number of people here today, the witnesses certainly. I think Olympia and I have known, coming in here, that we are all dedicated to the concept of having good health, but that depends upon having good health care, and having access to it. We are finding that access is deteriorating, especially in rural areas.

Winthrop Cashdollar of my staff and Marc Hartstein, who is on loan to me from HCFA have been very, very helpful in bringing this hearing together.

I especially want to thank my colleague, Olympia, who has worked with me, I guess, since we have been in politics together, to try to deal with this issue. We are not insensitive, Brian, to the issue of how much is spent on individual weapons programs, and we deal with that as well.

Mr. Rines. I just want to keep reminding you.

Senator Cohen. I am reminded. As a matter of fact, I voted to eliminate one of those B-2 bombers during the authorization program this year, and perhaps even more next year, because of the extraordinary costs and the question of its mission. It is something that we are required to deal with, national security as well as all the other programs that we are constantly balancing.

But I think the focus is shifting. It is one that deals with a lack of understanding.

We are having difficulty with—Olympia mentioned it, somewhat light heartedly—catastrophic health insurance. It started off as a good idea. President Reagan supported it. We thought that the aging community as such supported it.

I watched a program this morning in which one of the spokesmen for the AARP suddenly started backing away saying, "We didn't really support this program because of the financing aspect of it, but the devil made us do it. It was either take it or leave it. The President said this or it is vetoed."

So suddenly everybody is kind of reconnoitering now saying, "What do we do?" Because the real issue is going to be how do we finance long-term care. None of us have been able to come up with a solution in terms of the cost of that particular program.

So we are going through a reevaluation now. The Medicare Catastrophic Coverage Act undoubtedly can be scaled back. I do not know what it will look like after today or tomorrow. I suspect just some basic coverage. The Congress cut back the benefits and cut back the premiums.

But there is a lot of confusion regarding the Medicare Catastrophic Coverage Act. A lot of misinformation has been sent out as to who was going to pay and how much.

Your testimony has been very helpful to us and will build us a record. I hope that, as a nation, we will not find ourselves in the position that led one small community—I cannot recall in which State—to put out a wanted poster. It had "Wanted"—not dead or alive, but "Wanted, alive, $5,000 reward," for someone who would bring a physician into their community. We do not want to be in a position of putting out wanted posters for doctors.

Thank you very much.

Representative **Snowe**. I want to thank all of you as well for providing some very critical testimony for our hearing here today. I am pleased to be able to join Senator Cohen in this endeavor because I think it is critical that this issue be explored further. It is what we will be dealing with in the future, there is no question.

In terms of allocating our resources at the Federal level, the difficulty is not so much how much money, but how we allocate it.

It seems to me that one of the things we have to do is to change our policies. The environment has changed dramatically, and yet our policies have not changed to respond to this new environment.

Home health care services are a primary example of that. I have visited a number of homes where there have been home health care patients who have lost their services under home health care because of changes in Medicare reimbursement policy which are inconsistent and illogical in many instances. Unfortunately, the elderly people become the victims of that. The Federal Government has yet to identify home health care as a major priority, although it can cost less in the long run. The emphasis is still on institutionalization. That is also an important aspect, and appropriate at times as well. But we should be flexible in our overall policies to ensure that each individual has the type of care he or she requires.

So the question is of reallocating what we have and then deciding on the numbers of dollars that must be provided.

I appreciate all that you have had to offer here today.

I am glad to see my friend here, Brian. Nice to see you. Glad you could make it.

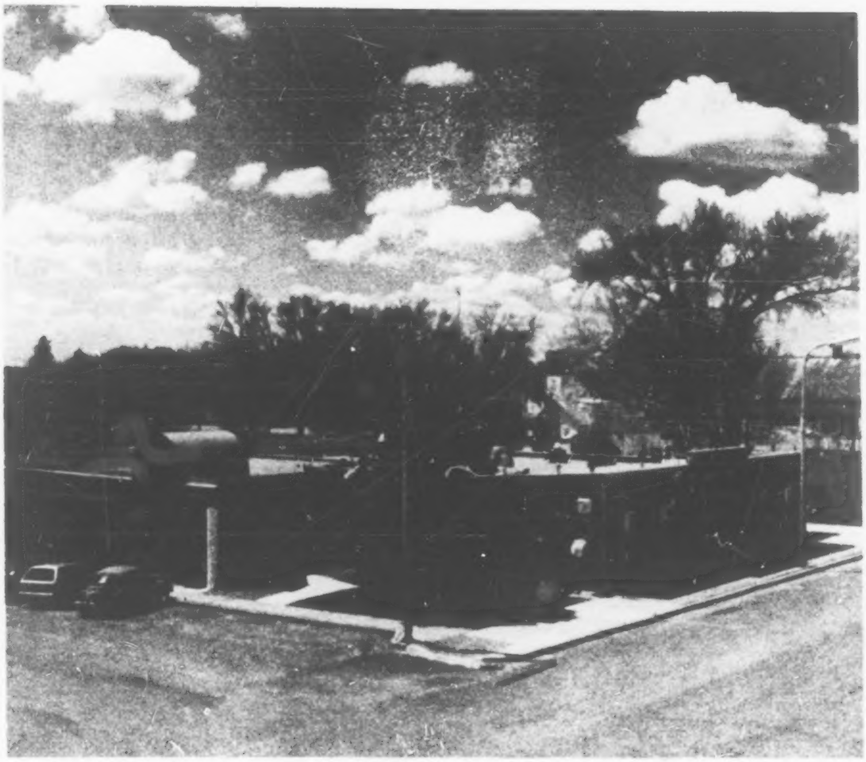
Thank you.

I want to thank my staff as well, Natalie and Dari from Washington, who are here. Thank you.

[Whereupon, at 1:10 p.m., the hearing was adjourned.]

APPENDIX

Item 1



Comfrey Hospital, in this quiet Minnesota town of 500, is the state's smallest—it has only eight beds.

By Richard J. Margolis

In America's small-town hospitals, a patient isn't 'just a number'

(From the Smithsonian, September 1989)

Yet its modern facilities include an operating room, outpatient clinic and 24-hour emergency room.

Rural America's local hospitals are facing an economic crisis, but their existence is often what keeps the communities alive

It happened one August night without warning, while our family was vacationing on an island off the coast of Maine. One moment Philip, our 12-year-old, was on a porch rocker joking with us; the next he was on the bare floor writhing in pain.

In a panic I carried Phil to his bed—he couldn't walk—while my wife, Diane, ran to get Alex, a Boston internist who happened to be summering at the cottage next door. "Torsion of the right spermatic cord," Alex pronounced, gazing down on our stricken son. Somehow a vital connection in Phil's groin had gotten twisted. The warp was choking off his blood supply.

"I've only read about such cases," Alex confessed. "Never actually saw one before."

Very tentatively he reached down and touched the tender area. Phil jerked and let out a howl. "Sorry," Alex muttered. He took Diane and me aside. "I think we better get your boy to St. Andrews right away. For something like this you don't want to wait too long."

St. Andrews Hospital lay an hour across the water in the little town of Boothbay Harbor. Could people who worked in such an out-of-the-way place be expected to possess the skills our son so urgently needed? We had our doubts, but there was no time to speculate. With another neighbor's help, we managed to get Phil down to the dock and onto a borrowed boat equipped with an outboard motor. In smooth, dark water we sped off, following a streak of moonlight that seemed headed toward Mill Cove and the hospital dock. Not another soul was on the bay.

"Maybe I can unravel this thing for you"

Alex had telephoned ahead. A nurse with a wheelchair and a blanket awaited us at the pier. Within minutes Phil was lying on a bed in the emergency room and being examined by a man who introduced himself as Dr. Gregory, a large man with lots of gray hair and a reassuring voice. "Let's see what we have here," he said to Phil. We held our breath and watched as the doctor's long fingers searched for the offending knot. Phil's body stiffened but he made no sound. "Just relax," Dr. Gregory murmured. "Maybe I can unravel this thing for you."

Between his thumb and middle finger the doctor was delicately kneading the invisible rope. Suddenly Phil's muscles went slack; he emitted a deep sigh. So did we—for it was plain that Dr. Gregory's educated fingers had untwisted the cord.

He patted Phil on the shoulder and stood up. "We'll want to keep you here overnight," he said, "just in case that thing decides to get troublesome again. You don't mind spending the night with us, do you?"

"Nope," Phil said. And for the first time in five hours, he smiled.

Photographs by Gail Mooney

All of the above occurred 19 years ago. Through the intervening years, until very recently, I held to the idea that our family's luck that scary night had been extraordinary, that in St. Andrews we'd happened upon a rare rural gem. Now I think otherwise. One of the many things I have learned from a recent round of visits to rural hospitals in several states (including an eye-opening return to Boothbay Harbor) is that our good fortune was just a routine entry in the annals of small-town medicine.

The knowledge has taken some getting used to. We live in a city that boasts two major hospitals, one with 491 licensed beds, the other with 875. Each in its way typifies the sort of high-powered, university-affiliated complex that most city dwellers equate with first-rate health care. By contrast, an urbanite's mental picture of a rural hospital is likely to resemble a faded turn-of-the-century etching, featuring ornate Victorian architecture, generally shabby upholstery and hopelessly primitive equipment.

Such hospitals did in fact once dot the rural landscape. Writing a half-century ago, here is how Arthur E. Hertzler, a Kansas country physician, reminisced about those early institutions in his autobiography, *The Horse and Buggy Doctor*. In his youth, Hertzler recalled, the typical small-town hospital was "in a private residence. . . . Sometimes the doctor and his family lived downstairs and the wife did the cooking. . . .

"Usually half a dozen or fewer hospital beds found available space in these houses. The operating room was usually the bedroom of the former cook. . . . The kitchen stove usually supplied the heat for the sterilization of the instruments and dressings. This made it necessary for the doctor to eat an early breakfast, so that the stove could be available as a sterilizer when it came time to prepare for the operation. Operating in such hospitals was but slightly removed from the kitchen surgery of any private residence. . . .

"It is enough to make one weep," Hertzler mourned, "to think back on those early beginnings."

Urban medical centers in miniature

These days the good doctor would not have to weep. The hospitals I visited were indeed small in comparison with their big-city cousins—they ranged downward from 75 beds to a mere 8—yet they gleamed with modernity. In most instances my first impression was that of an urban medical center in miniature. Even the most Lilliputian of them all—the one in Comfrey, Minnesota, with its eight beds—boasted an outpatient clinic, operating and recovery rooms, a blood bank, a pharmacy, a 24-hour emergency room, delivery and nursery facilities with two bassinets, and social services. Many maintained intensive care rooms equipped with

Dr. John Hahn delivers twins by C-section at Grant Memorial Hospital, in the mountains of West Virginia.

monitors that could flash the jagged trajectory of a patient's heartbeat.

But rural hospitals do not compete with their urban counterparts—at least not in cases requiring the more exotic skills and technologies. "Don't come here if you need open-heart surgery or a kidney transplant," says Dr. Matthew J. Rimas, Comfrey Hospital's only full-time physician. "But for most illnesses you can get as good medical care here as you can anywhere." (Like many small hospitals, Comfrey has access to a helicopter for emergency transport of patients whose ailments defy the hospital's healing powers.)

Even as I sketch this picture, however, I have an uneasy sense of having left out its most remarkable feature. Call it one-on-one graciousness; call it sympathy; call it, for lack of a better pun, small-town hospitality. Whatever the label, it is a force that operates at the very center of most rural hospitals in America. Yet it is so universally taken for granted, that hardly any of the scores of doctors and nurses I talked with seemed conscious of its presence.

"Do you do anything special for bereaved families?" I asked a nurse at Grant Memorial Hospital, a 59-bed facility tucked into the mountains surrounding Petersburg, West Virginia.

The nurse, a veteran of many years' service, gave the question considerable thought. "No," she finally answered. "I don't recall our ever doing anything out of the ordinary for the bereaved. Oh, sure, we cry with them and we sing with them and we pray with them. But no, nothing you could call special."

Pies from scratch, real mashed potatoes

A rural hospital, then, may be a place where nothing "special" ever happens. Where no one is a number; where everyone knows your name, tolerates your quirks and shares your griefs; where the nurses celebrate your birthday. Where, when you telephone to say you feel sick and wish to be admitted, they turn down your bed and have the florist deliver a half-dozen pink carnations to your room. Where visiting hours do not matter even if they are posted—relatives and friends come and go as they please; where a turned-on light over your door instantly brings a nurse to your bedside. Where the kitchen staff makes bread and pies from scratch, and *real* mashed potatoes, and if you don't like the evening menu, someone will run to the corner and bring you a pizza with mushrooms and onions—and no anchovies. Where your tattered pajamas may be mysteriously replaced one evening by a brand-new pair, with the price tag removed. ("For what us nurses make around here," one of them at Grant Memorial marveled, "we sure are free with our money.")

Such everyday dispensations are all duly recorded in my notebooks. They have become part of my education. From them I conclude that small-town hospitals draw energy from secrets all their own: within the national health care system, they emerge as unique institutions where the curing and the caring are one and indivisible.

At Grant Memorial I was introduced to a patient whose lengthy sojourn there—not yet over—perfectly illustrates the bond between caring and curing. The patient's name is Shane. He is a dimpled, brown-eyed infant born about three months prematurely on January 14, 1988, at West Virginia University Medical Center in Morgantown.

Shane had two and a half strikes against him. Within weeks after birth he went into heart failure and barely

Student nurse Becky Calhoun comforts a sick baby at Grant Memorial, where she helps out in summer.

At Grant Memorial, the pulse of activities (shown in the photographs on these pages) includes a hectic change of shifts, as day nurses take over from the night staff. One doctor says of the nurses, "We need the tops in the class. We have to rely on them to be able to do anything—because we are all alone out here."

A physical therapist, Tammy Evans works with a stroke patient to help him recover some movement. The hospital maintains a full-time physical therapy department and a fully stocked pharmacy. Many patients must come 60 miles on bad mountain roads. But, as one doctor points out, "Where else would they go?"

survived. Among other things, he was suffering from a malady doctors have dubbed "stiff lung"—the technical term is bronchopulmonary dysplasia—meaning that his lungs were unable to absorb oxygen. There is no known cure.

For five months the doctors and nurses in Morgantown kept Shane alive. They gave him oxygen through tubes in his nose; they fed him nourishment through tubes to his stomach. Then, with little hope for Shane's future, they sent him to Moorefield, where his 18-year-old mother worked in a chicken-processing plant.

Shane still required around-the-clock medical care. He ended up in Grant Memorial. "You should have seen him when we got him," says Linda Davis, director of nursing there. "It was pathetic. He just lay in his little crib without moving or making a sound. A baby at 6 months is supposed to laugh and cry, but Shane couldn't do either. Absolutely no facial expression: he didn't smile, he didn't frown. Then we discovered he couldn't suck very well, which meant we needed to feed him very often and in very small amounts. Believe me, Shane was one sad baby."

What happened next seemed entirely spontaneous and unrehearsed. "We sort of adopted him," Davis recalls. "We treated Shane like our own." The nurses gave him toys to play with; they clothed him in new, colorful nightgowns; they kept talking to him, cooing over him, picking him up and carrying him around.

As Cathy Crites, another nurse at the hospital, notes with severe approval, "That baby was spoiled rotten.

Richard J. Margolis is a freelance writer concerned about rural America. He wrote on volunteer fire departments in the November 1983 SMITHSONIAN.

Dr. L. R. Littleton reads x-rays on visit to the hospital. He is licensed in 12 states and travels to small rural hospitals to render services as a radiologist wherever needed. A pathologist also comes to Grant Memorial regularly and technicians stay in touch with his laboratory by telephone.

Cathy Crites, R.N., inserts an intravenous tube into a 6-month-old baby, as Nurse Pat Shoemaker assists. Asked why she wears cap, Crites says, "In school we were taught to wear clean white shoes, white hose and a pressed, clean white uniform—and your *hat*. I worked really hard for this hat and I am proud of it."

When we had to do our charting at the desk, we took Shane with us and let him sit on our laps while we wrote out our reports. I don't think we hardly ever set him down."

In time Shane began to respond to all the attention. He learned how to laugh and cry. His new talents only increased the pampering. "Whenever he cried," says Crites, "one of us would pick him up right away. We were in terror he'd choke to death. Of course he caught on right away and he cried all the time. It was a kind of blackmail."

Shane also learned how to eat from a spoon, but only when the spoon was proffered by one of the full-time nurses familiar to him. "The part-timers never had much luck feeding him," Crites says. "But when one of us full-timers offers the spoon—Wow!"

On Shane's first birthday there was plenty to celebrate. He was six times his birth weight—he now weighed slightly more than 14 pounds—and most days he was able to breathe without benefit of oxygen tubes. At his birthday party, says Mary Beth Barr, the assistant director of nursing, "Shane giggled and ate cake with a spoon. We were so proud of him. He's such a *good boy*."

I had set out to learn about small hospitals because I had heard they were an endangered species. I wanted to see what we as a nation stood to lose if we allowed these modest facilities, largely hidden from metropolitan eyes, to vanish. From a rural perspective, of course, such a loss would be catastrophic, not only in terms of the local residents' health (and the local economy) but also in terms of their pooled pride. For there is something about a small-town hospital that can inspire an altogether refreshing awareness of civic consequence. As a housewife who has lived all her life in Indepen-

Text continues on page 60

Rhythm of small-town life is apparent in the daily routine at Comfrey Hospital, as pictured in this series. The eight beds in this otherwise modern facility are still raised and lowered by hand crank. Here, Nurse Elaine Tindeland adjusts one carefully for a patient.

"We make everything from scratch here," says Bernetta Helget, who sets out her "delicious cookies" to cool.

Signe Quarnstrom donates 30 hand-sewn quilts to the hospital, as lap robes, in memory of her husband.

Dr. M. J. Rimas (Doc) and R.N. Shirley Christensen check patient, their expressions as healing as medicine.

Doc Rimas lifts 5-week-old Rachel, whose grandmother is a nurse here. Many of Doc's patients are friends.

A native Comfrey resident, Jerry Savage gets a shave and TLC from Nurse Elaine Tindeland. The nurses work long, hard hours, often staying into the next shift to help out. This day, when extra patient was admitted, a nurse said "Give her my dinner. I'll have some soup."

Comfrey nurse Diane Witt meets patient Leo Hoffman. Hospital has an outpatient clinic and provides social services as well. Following his visit, Hoffman remarked, "This is my home. These people are my family. If this hospital goes, next will be the school, then the town."

dence, Iowa (pop. 6,150), reminded me, "It's simply a matter of our self-respect. A town that loses its hospital has one less thing to be proud of."

Many small communities nowadays are having to face the indignities of subtraction. Of the 2,599 rural hospitals still extant—most with fewer than 100 beds—quite a few are verging on bankruptcy and each year some 40 are going belly-up. A study published recently by the U.S. Senate Special Committee on Aging predicts that over the next few years as many as 600 more will have to close their doors (80 in Texas alone).

Nobody knows for sure how to diagnose this disorder, much less what remedies to prescribe. While depressed rural economies are often a factor, the villain rural partisans most frequently single out, surprisingly, is none other than Medicare, the federal health insurance program for the elderly. In part, that is because Medicare reimburses rural hospitals at a substantially lower rate than it does urban hospitals. The difference has amounted to about 20 percent, and can go as high as 50 percent in some hospitals. In addition, Medicare's system of payments inadvertently penalizes small-town hospitality.

In the past, Medicare and hospitals had maintained a kind of gentleman's agreement whereby hospitals were trusted not to levy unreasonable charges for elderly-patient care. It was Medicare's custom to pay hospitals whatever amounts they requested, with little scrutiny. However, this blank-check approach to doing business probably encouraged considerable hospital inefficiency and avarice, in about equal parts.

Congress changed all that in 1983. Nowadays, instead of presenting a blank check, Medicare hazards a prediction of how long each patient is likely to be hospitalized, and then bases its payment strictly on that forecast. The new system may have saved taxpayers some dollars, but it has posed cruel dilemmas where patients require lengthier hospital stays than Medicare is prepared to compensate.

Such cases can be costly, which is why city hospitals rarely hesitate to discharge a patient who is no longer covered by Medicare. Quite a few rural hospitals, on the other hand, prefer to keep the patient and damn the expense.

The Henryetta Medical Center, a 52-bed facility in Henryetta, Oklahoma (pop. 6,290), is one of those. About three-fourths of its patients are insured by Medicare. In a three-month period, says James L. Clough, the former administrator there, "we lost nearly $80,000 on just six patients." Clough has meticulously described one of the six cases in a letter to Representative Mike Synar of Oklahoma.

An 80-year-old man dying of cancer was admitted to the hospital. His legs were paralyzed; he was in severe pain and required a morphine injection every four hours. As Clough tells it, "Attempts were made by the hospital and physician to place the patient in a skilled nursing facility located in Tulsa [47 miles away], but there were no beds available." The possibility of home care, with nursing visits, was also discussed. But it turned out that the man's wife couldn't provide, by herself, the care he needed throughout the day.

Volunteer Evelyn Shobe, retired Petersburg beautician, visits monthly to do patients' hair, charging nothing.

Finally, Clough continues, "it was decided that the patient would have to stay at the hospital." He died there 68 days later. The hospital sent Medicare a bill for $26,660. Medicare sent back a check for $2,477 and marked it "Paid in Full."

Medicare rules aside, the simple dictates of neighborliness can play havoc with a small-town hospital's tight budget. In many such communities it is taken for granted that the poor no less than the affluent are entitled to medical care. To rewrite Robert Frost's famous dictum about home, a rural hospital is a place where, when you have to go there, they have to take you in. That is why village hospitals tend to donate more than their share of what health care commentators like to call "unreimbursed services."

At Grant Memorial I met an 88-year-old patient—the nurses called her "Miss Judy"—who had been there 48 days following gall bladder surgery. So far she'd run up a bill of more than $55,000, while Medicare's 15-day limit called for reimbursement of only $9,742. "She's got a daughter who works," explained Linda Davis. "How can we send her home when there's nobody to take care of her?"

A sign in the lobby of Grant Memorial tells the story: "Payment is expected when services are rendered unless other arrangements have been made in advance." In a region famous for poverty, those "other arrangements" can be costly to the hospital. "We don't turn anybody away," says Robert L. Harman, Grant Memorial's friendly, low-key administrator. "One way or another, we'll cover it."

Dr. John L. Hahn, the hospital's only obstetrician, told me that he delivers about 300 babies a year, and two-thirds of his patients are on Medicaid, the combined federal and state health insurance program for poor people. But Medicaid pays only about a third of Hahn's actual bill. "When somebody's down and out," he said, "I don't go after the rest of the money. I know what it's like to be poor." Then he added with a smile, "Don't advertise that."

"We did it because it was right"

People's Memorial Hospital in Independence, Iowa (20 miles east of Waterloo), nicely exemplifies this form of economic hospitality, so different from what patients experience in city hospitals. "When the farm crisis hit us a few years ago," recalls Robert J. Richard, the hospital's administrator, "we tried to make things easier for the families who were hurting most. Lots of them had no health insurance—the farmers could no longer afford it, and quite a few of the workers in plants around here got laid off, so they were unprotected, too. We made it a point to accept every patient who needed care. It cost us a bundle, maybe a quarter of a million dollars, but that was OK. We did it because it was right. We're very much a part of this farm community. Our social mission is paramount."

But, perhaps because this was Iowa, some proud patients inevitably objected to the hospital's generosity. "I don't mean to be disrespectful," an impoverished farmhand, the father of three small children, wrote to Richard after the hospital had written off a $380 charge for his daughter's stay there, "but I just can't understand how you could do what you did to me. I intend to pay you back every cent." And he did.

Administrators and board members who have been entrusted with the fate of their town's only hospital can be understandably pessimistic these days. In a recent national survey of hospital administrators taken by the accounting firm of Touche Ross, 48 percent of those heading small hospitals thought their institutions would fail in the next five years. On the other hand, hope in rural America really does spring eternal—the citizens there have no choice—and where there is hope, there may also be energy and imagination.

Consider the case of the Central Valley Medical Center, a 30-bed hospital in Nephi, Utah. The dietitian there, along with her kitchen staff, had to be on hand even when there were only two or three patients to feed. So the hospital administrator, Mark Stoddard, put them to work baking birthday and wedding cakes (from scratch, of course), not to mention Christmas cookies and Valentine cupcakes, and selling them to local customers. The profits, about $3,000 a year, help to defray the hospital's food bill.

"We're trying to do everything we can to make ends meet," Stoddard says. To cut down on expenses, Nephi (pronounced "knee-fi") has taken a step that many independent-minded rural hospitals nowadays find distasteful but necessary. It has teamed up administratively with the hospital in Gunnison, 41 miles down the road. The two institutions buy supplies together, rely on some of the same specialists and use some of the same mobile equipment. Stoddard administers both.

Comfrey Hospital in southwestern Minnesota, which serves a farm community of some 1,800 people, has taken a similar step. The state's smallest hospital, it has joined with four others in the area to form a portion of Health Network of Minnesota, a coalition of hospitals in and around the southwestern part of the state. But in Comfrey's case the collaborative spirit may be turning sour.

At Grant Memorial, Nurse Cathy Crites takes a moment to hug one of her patients. And they love her, too.

"We're the underdog," says Gary Richter, the young editor-publisher of the *Comfrey Times*, "but we're going to fight the odds." The odds, according to an areawide study conducted by a Denver consulting firm, are not favorable. "There needs to be a reduction in the number of inpatient beds," the consultants concluded. They singled out Comfrey and nearby Mountain Lake as prime subtraction prospects.

But as Richter says, reflecting the peculiar cussedness of rural logic, "Those are just facts. You don't necessarily have to go with them."

A few days after the Denver report was made public, the townspeople decided not to go with the facts. At an emergency meeting, nearly everyone expressed an interest in "keeping the Comfrey Hospital going"; more surprising, a majority of residents favored the levying of a special hospital tax.

Rural Americans are not generally known for their spendthrift ways. When a group of small-town citizens eagerly volunteers to pay more taxes, they are sending a singular message about their beleaguered hospital: from where they sit, it is indispensable.

I learned more about the fierce local loyalties a hospital can engender when I returned to St. Andrews in Boothbay Harbor, Maine, thereby completing my rural round robin. Much had happened since our fortuitous visit 19 years ago. The old building, where Dr. Gregory had so deftly unraveled our son's distress, had become a 30-bed nursing home. Attached to it was a new, 22-bed acute care wing, built at a cost of $2.3 million and opened in August 1987.

A hospital with familiar rural ailments

At first glance, all seemed well at St. Andrews. A second look, however, tended to darken the rosy picture. A few years back, I was told, the hospital began to be troubled by some familiar rural ailments. Its occupancy rate dropped to 28 percent. At one point the pinch was so bad that St. Andrews' staff, ever the cheerful givers, had consented to accepting a 20-percent cut in their pay.

Each year brought with it another discouraging deficit, and St. Andrews was driven to the very brink of ceding its cherished independence to a slightly larger hospital (27 beds) in Damariscotta, a town on the next peninsula, some 20 miles to the north.

But the merger plan was scuttled by aroused townspeople, and the harbor air has been calmer and brighter ever since. Contributions from the residents, including a fair proportion of affluent summer people, had covered the new construction costs, so the hospital was free of debt. Last year, moreover, its 14-member unsalaried board of trustees had taken steps to firm up the hospital's administrative arrangements. They had signed a managerial contract with the Hospital Corporation of America, an international chain that owned 79 hospitals and managed 225 more. St. Andrews is doing better this year; it has recruited several more doctors to its ranks; and its occupancy rate has risen a notch. One trustee remarked recently, "For the crisis we went through, we're coming out of it not too badly."

I had been hoping on this visit to shake the talented hand of Dr. Gregory and to thank him once more for his ministrations to our son that strange summer night long ago. But I was told that Dr. Philip O. Gregory had died in 1983 at the age of 73. He was the son of St. Andrews' founder, Dr. George Gregory, a Nova Scotian who had migrated south in search of a viable practice. "Dr. George" opened St. Andrews on August 1, 1908, naming it for the patron saint of commercial fishermen. Large oil portraits of both father and son gaze down on the hospital's main corridor.

I spent the night at St. Andrews, not certain what I was waiting for. Nothing spectacular occurred—there were no emergencies—but in a small-town hospital, every night produces its own kind of quiet drama. Call it a theater of compassion.

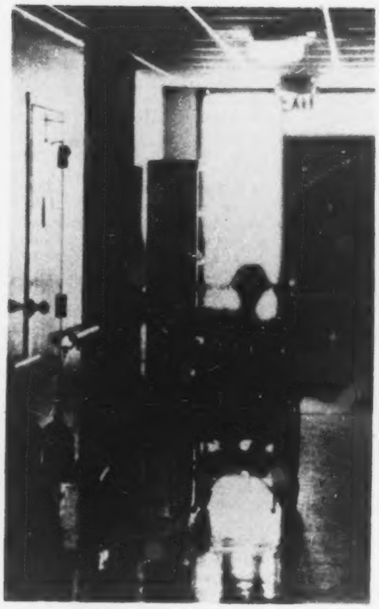
The night's protagonist was Marilyn, a gaunt, middle-aged woman who had recently been operated on for gallstones. It was her third operation in ten months, so the nurses were not surprised when Marilyn started to hallucinate. "It's the anesthetic," explained Irene Fowle, one of the evening nurses. "It can cause a chemical imbalance. You have to take her seriously. She's really scared."

"An Indian" under Marilyn's bed

First Marilyn complained that the corridor was full of water, and the water was rising. "I can't swim," she confided to a nurse. Later she called for help because she had discovered "an Indian" under her bed. "What does he want with *me*?" she wanted to know.

As it happened, all beds were occupied that night and the nurses were kept busy. But to Marilyn they betrayed no sign of impatience. They answered her calls instantly, comforting her as best they could and pretending to look beneath her bed for hidden marauders.

When all else failed, a nurse's aide named Krista Greenleaf helped Marilyn don leather slippers and a flowered robe, and then walked her up and down the corridor, cooing to her as sweetly and soothingly as the



In Comfrey hallway, patient works out with makeshift weight-and-pulley system, installed especially for him.

nurses in Petersburg had cooed to Shane. Eventually they made her comfortable at the nurses' station, tucking her into an enormous leather chair, with two pillows behind her head and a woolen blanket draped over her wispy figure. She sat there much of the night, scowling at me and the nurses. With her hair done in braids and her feet dangling several inches above the floor, she looked like a gray-haired child. "I'm frightened to death," she said to no one in particular. "I don't want to stay here and have everyone get hurt."

Krista Greenleaf spoon-fed Marilyn some medicine and hot tea from a plastic cup. "Hush," she said. "You stay right here with us. We need the company."

In the morning I had an appointment with Peggy Pinkham, the hospital's community relations director. "Would you like to see your son's records?" I was asked. The question surprised me. "Do you keep those things?" I asked in return.

Within minutes I was handed a stapled sheaf of papers. At the top of the first sheet someone had typed: "Name: Margolis, Master Philip E. Age: 12. Admitted: 8-29-70. Discharged: 8-30-70. Admission Diagnosis: Torsion (twisted) spermatic cord on the right."

Fascinated, I began turning pages. There were laboratory blood tests, temperature readings, blood pressure readings, three separate pulse notations and a comment on Phil's respiration ("normal"). At 10:15 that night Phil had "taken well" some soup, a sandwich and a glass of milk. About an hour later he "appeared to be sleeping." At midnight he was still "sleeping quietly." At 8 the next morning he seemed just fine. "Asymptomatic," someone had written on the chart. "No swelling."

What came over me as I read those precisely scribbled notations was a good deal of ex post facto gratitude. While Diane and I had slept in our vacation-cottage bed, there had been people three miles across the bay keeping wide awake. All night they paid strict attention to our son's health and comfort. It seemed to me he had been in the best of hands.

Partially paralyzed by an accident, a patient is given physical therapy for his hand by a visiting practitioner.

"For most illnesses," avows Doc Rimas, "you can get as good medical care here as you can anywhere."

Item 2

Rural Maine invests in a doctor

By Judith Gaines
Globe Staff

OXBOW PLANTATION, Maine – Getting and keeping good doctors had been a longstanding problem for the people of Oxbow, Portage, Ashland and other communities in rural Aroostook County. So they decided to try a novel approach.

They levied a mandatory tax.

The idea was hatched by Roger Pelli, a native of Providence who had worked in the Aroostook area for five years as a physician's assistant. When doctors at a local hospital encouraged him to become a full-fledged physician, Pelli was intrigued. But how could he raise the $100,000 for medical school tuition and expenses?

Pelli figured he could raise $20,000 through a state program for rural physicians and another $20,000 through a federal graduate student loan program. But that left $60,000 – plus the problem of getting accepted at medical school. Having been rejected previously by several colleges, he knew he needed some way, some unusual way, "to make my application noticeable."

As a physician's assistant, Pelli believed he had developed a special rapport with the people he served. "It was not uncommon to open the back door and find 100 pounds of potatoes on the steps, or to have five snowmobilers ride up to the house

PELLI, Page 6

Rural Maine invest

■ PELLI
Continued from Page 1

and say, come on, let's go to Portage for a pizza," he said.

So he devised a bold plan to simultaneously raise the money he needed and land himself in medical school by proving his commitment to the profession and to his patients, and by showing their support for him.

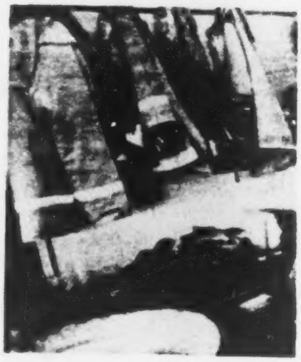
Pelli calculated that if everyone in the area he had served as a physician's assistant – people mainly in the towns of Ashland, Masardis and Portage, and in the plantations of Oxbow, Nashville and Garfield – would agree to pay $5.75 per person per year for four years, they could put him through medical school.

In return, he would promise to be their doctor for at least eight years – two years of service for each year of education – or to repay the loan, plus a hefty interest rate.

Pelli approached local leaders with the plan. From June to August 1982, public meetings were held in each of the six communities to discuss it.

A few residents were skeptical. "We'd seen doctors come in, set up office, and first thing you know they're gone to Bangor or Presque Isle," said Donald O'Clair as he repaired a jeep in his Ashland gas station.

"Some people were afraid once he'd gone to them big schools and the big cities, he wouldn't want to come back," O'Clair said.



Dr. Roger Pelli fondly remembers as Ashland.

As Virginia Pinkham, chief administrator of the Aroostook Valley Health Center, explained, Aroostook County has never been thickly settled. "They call it the woods frontier," she said. "Between here and Quebec, you'd go about 100 miles without finding a paved road."

Pinkham said some doctors have been reluctant to come here – or to other rural areas – because they feared "they'd be isolated from their peers, or their families would have culture shock, being so far from theaters, plays, big stores and all. Or they weren't willing to be so far away from places where they could get continuing medical education."

Some physicians came nonetheless, but lasted just a year or two. "With only one doctor in the area, I think they felt like they were always on call," Pinkham said. "They got burnt out."

So, to most folks, Pelli's plan looked like an inventive remedy for an old sore.

"How could a person go wrong?" asked Jerry Dunham, a former truck driver living in Garfield plantation (pop. 107). "We were guaranteed a doctor or our money back.

"There's just no way a good doctor would stay here when he can get so much more money in the bigger cities. We had to have some other way to get him here."

Pauline Craig of Masardis remembered the mood at town meeting. "People thought he had worked hard as a [physician's assistant]. A lot of folks liked him, and he was very involved with the community. He just seemed like family to us."

"The money didn't seem like so much," said Phyllis Hutchins, mayor of Oxbow (pop. 75). "At least we wouldn't have to worry about robbin' up another community for a doctor."

By the end of August 1982, all six communities had voted to levy a four-year tax at the rate of $5.75 per person per year to put Pelli through medical school.

And the strategy worked: He was accepted at the University of New England's College of Osteopathic Medicine in Biddeford, Maine. (Osteopathic medicine, Pelli explained, is almost identical to more conventional medicine, except that it includes "hands on," manipulative techniques to encourage the body's natural healing capabilities.)

During his seven years of training, Pelli "wrote home" periodically, keeping the communities informed of his progress and reassuring them, as he wrote in a letter dated Jan. 12, 1986, that he and his family were "still looking forward to returning to live and practice medicine in your area as much as ever."

The letters were posted at local markets, gas stations, post offices and other community gathering points.

Launches practice today

Pelli graduated second in his class, completed an internship, and now has returned to Aroostook County. Today he begins work as the only physician for the 2,870 people in the six pioneering communities.

"We're glad to have him back," said Nancy Farris, Ashland's town manager. She thinks the communities' innovative approach "can serve as a model for other small communities having difficulties attracting and keeping quality health service" – or other kinds of public service, for that matter.

Already Farris has had calls from other students hoping to apply the idea to their own situations, and from other communities wanting to know more about how the plan worked.

For his part, Pelli is apprehensive but eager to begin. "I know I have to be something special. I'm not taking [the local people] for granted just because I'm the only game in town," he said.

"I think I'm very fortunate," Pelli said. "I had offers of better-paying jobs, but this is the place I want to be. This is home. It's the truth.

"I get reaffirmed every day with the kind of support you can't put a price tag on. I feel needed. I feel appreciated."

Item 3

METHODIST CONFERENCE HOME, INC.
39 Summer Street • Rockland • Maine • 04841 • Tel. (207) 596-6477

September 15, 1989

Senator William Cohen
Representative Olympia Snowe

Health Care for the Rural Elderly

The staff of the Methodist Conference Home would like to take this opportunity to share our concern regarding the lack of adequate long-term health care for the elderly in Knox County, Maine. The MCH has been serving the elderly for twenty years - as a congregate housing facility, provider of meals on wheels, and affiliate of the regional transportation program. We interact with over 200 Knox County senior citizens daily. We are very concerned that home health options are very poorly funded, nursing home waiting lists very long, and rural elderly very isolated.

We have a long-standing commitment to provide meals on wheels to every older person in need of this service. With the waiting lists for home care services, at least we can be sure someone will check in on the homebound elderly person five days a week and they will have one good meal a day. Our ability to continue to provide even this small measure of support to everyone in need is in jeopardy, for we receive fewer federal dollars today than we did in 1984 and fundraising over $30,000 per year from small communities is increasingly difficult. I hesitate to think how great the reduction in federal support would be if we calculated the impact inflation has had upon our level of funding.

I would like to share the stories of three of our residents with you. Please keep in mind that these people are comparatively very lucky - they live in subsidized elderly housing with a federally funded Congregate Housing Services Program. They get three meals per day, weekly housekeeping and laundry services, a weekly bath, and assistance with transportation. They have neighbors on the other side of a wall, and emergency response systems.

1. Mr. F. is an 85 year old man with a deteriorating physical condition caused by Parkinson's disease, urinary incontinence, and organic brain syndrome. He has difficulty handling his medications, which are pre-poured by the local home health agency. While Mr. F. has been determined to be eligible for nursing home placement, he has been unable to move to a more appropriate level of care because the three local nursing homes to which he has applied have no male beds open. Mr. F. has been awaiting placement since January, he is on medicaid. In personal terms, this situation means Mr. F goes through the weekend without anyone to help with the problems caused by incontinence - changing sheets, cleaning floors, etc. and without anyone to help him bathe. The lack of adequate service literally results in older people being forced to live in their own waste.

2. Mrs. C is an 87 year old woman whose increasing frailty has left her less able to interact with others. She has become more isolated and consequently depressed. She cannot afford to pay for companion services privately so she was referred in early April to the AAA for evaluation for additional services. She was put on a waiting list and, due to lack of funding, has not been visited yet for an assessment.

3. Mrs. H is an 87 year old woman who suffered a heart attack recently and needs support beyond that provided by the CHSP to continue in her apartment on a long-term basis. She has also been put on a waiting list for assessment as funding is not available through the AAA home care programs.

Waiting lists, while a fiscal necessity, are a cruel tease to people who desperately need service. In two of the instances described above, they also illustrate the fiscal absurdity of the allocation of our resources. Both women are at risk of nursing home placement at approximately $65 per day. Currently, their services and rent at the MCH cost roughly $15. per day. Additional services could be provided, keeping these women at home, and still cost less than nursing home placement. Both are very low-income and will ultimately be subsidized by medicaid in a nursing home.

As I mentioned earlier, in many ways these people are lucky, certainly our meals on wheels clients on waiting lists for home care are in more desperate circumstances. And the pressure upon service providers is substantial as well. Long distances between clients (one of our meals routes is 75 miles long), lack of staff for aide positions, rising costs of fringe benefits, and difficult weather conditions during many months makes service provision more expensive and puts increased pressure on very limited resources.

One cannot help but wonder where our values and priorities are as a country. As Congress debates tax cuts, elderly homebound people suffer in loneliness and isolation. Your attention and commitment to their needs and concerns is welcomed and appreciated.

Thank you.

Margaret S. Haynes
Executive Director

Item 4

Down East Community Hospital

R.R. 1 • BOX 11 • MACHIAS, MAINE 04654 • (207) 255-3356

September 29, 1989

Honorable William S. Cohen
United States Senator
Senate Special Committee on Aging
Aging Hearing
P. O. Box 1938
Portland, Maine 04104

Dear Senator Cohen:

Thank you for the opportunity to add testimony to the September 18 Bangor joint hearing on "Problems Faced in Delivering Health Care Services to the Rural Elderly." I have read the available statements given to me by presenter Mr. Roy Gallagher of East Machias and commend each of the participants on the uniform excellence of their work.

I first came to Down East Community Hospital in 1965, four months after it opened. I left in 1969 and returned slightly more than nine months ago. I was here when Medicare came into being and have witnessed all its gyrations. It has changed from a program that benefitted the hospital in its early undercapitalized days to one that direly threatens it now.

During the time span of my involvement, DECH has generated revenues of $67,000,000 in this community. Nearly $26,000,000 of that has been payroll. It has delivered 4,500 babies and a quarter million days of patient care. We average 140 full-time equivalent employees. We support sixteen active staff and fifteen consulting staff physicians. Many of the employees and physicians would not be here if it weren't for the hospital.

We are 60 miles of rough two-lane highway from the nearest hospital on one side and 45 miles of even tougher road on the other. The nearest referral center is 90 miles away. There is no doubt whatsoever that the loss of this hospital would be catastrophic to the 15,000 - 20,000 people we serve and devastating to our communities. Yet we are in real danger from a program designed to provide equality of care to the elderly, an apparent thrust to close the hospitals made possible by Hill-Burton legislation, a regressive state healthcare financing system, and a growing takeover threat by referral hospitals.

At times I worry that there is a federal design to squeeze rural hospitals so hard that most of them will disappear!!! What strategies are being hatched at the Department of Health and Human Services or in the minds of legislators like Mr. Stark? Do you know? Should you? Is there or is there not a desire to eliminate rural hospitals? We need a clear and believable answer.

Please consider some raw economics taken from the 1988 AHA Guide to the Health Care Field. Maine Medical Center listed total one-year expenses of $146 million; Eastern Maine Medical Center listed $92 million; Down East Community Hospital listed $5 million. One hospital in New York City (which has more than 80 other hospitals) showed one-year expense of $475 million. That alone would fund 95 Down East Community Hospitals and its loss wouldn't have nearly the impact on New York City that the loss of DECH would have to Machias. Imagine closing 95 rurals to equal one inner city.

Think also please of what happens when a Machias type of hospital is closed. Are there real savings or does the travel, longer stay, and higher cost medical center absorption quickly exceed the original costs. What of the local displacement. Is governmental dole needed to replace the payroll losses?

There are a bunch of things rural hospitals can and must do to lessen economic dilemma; many of them have been detailed already. I believe we need deregulation of the rurals. We are financially miniscule in the scope of things. I believe we need different rules that look at our mission rather than the cookbook philosophy now in use. We need to network expensive positions. Why can't a competent administrator manage more than one facility. The same with chief financial officers, materials managers, human resource managers, etc. Why shouldn't we develop the long-term care facilities and provide from the hospital their common needs like administration, dietary, business office, maintenance, etc. Why don't we spread our labor costs more efficiently by providing senior citizen meals, doing physician billing, providing day care and so on? The real reason is that regulations make it so difficult that it becomes counter productive.

Much of this communication has dealt with hospital issues because it is integrally related to delivering health care to the rural elderly. Additionally, we believe that a generally limited population base causes the elderly to have less than optimum access to Home Health Programs, Hospice, access to Long-Term Care and Ambulatory Services. Almost any improvements in such programs would result in a net savings when compared to inpatient acute care service.

Down East Community Hospital is a necessary and vital resource. It has the competence and will to survive. It, like others, is being strangled by regulation. Help make the rules commensurate to our role and we will continue to deliver quality primary care to all who need it. Handouts and subsidy aren't really necessary. The opportunity to control our destiny is.

Thank you for the opportunity to comment.

Sincerely,

George Avery, FACHE
Administrator

GA:ebb

Item 5

201 Husson Ave.
Apt. Noble 8
Bangor, ME 04401
1-945-6715
September 29, 1989

The Hon. William S. Cohen
United States Senator
United States Senate
Washington, DC 20510

Dear Sen. Cohen:

Prior to the hearing on rural health care which was held jointly with Rep. Olympia Snowe in Bangor, I had inquired about giving testimony. I was told by Rep. Snowe's secretary that written testimony would be welcome.

I testified at the Maine Legislature's Blue Ribbon Commision Hearing on Health Care Expenditures, a photocopy of that testimony is sent herewith.

Additional testimony is also sent herewith in the form of a letter adressed to Rep. Snowe, but which is identical in form with that which would be sent to you, Therefore, a photocopy of the letter will save time for me, and, I'm sure, will serve the purpose intended.

The hearing was well worth attending. I must say, that, because the patients seem to be treated as inanimate objects under the cost-containment regulations, that it was quite encouraging to see and hear a lot of people who were speaking out in our behalf, understanding that we are live human beings with varying problems which cannot be met with such rigid guidelines as are at present being used. It is relevant to add as well, that I watch people bring shopping carts loaded to overflowing with returnable bottles and cans, representing huge amounts of money spent on products of neither lasting value nor nutritional value, and I observe long rows of shelves offering popcorn, potato chips, corn chips, and a host of other munchies that, used in excess as they are being used, help fill our hospitals needlessly, and I hear the protest that this nation cannot afford to help its disadvantaged people--even the worthwhile disadvantaged--I want to weep for our country, where this and other frauds are becoming the rule rather than the exception. But, then, Sen. Cohen and Rep. Snowe, come into the hinterland to see if they make a difference, and the world looks a little brighter with hope.

Sincerely yours,

(Mrs.) Elizabeth Whitehouse

Enclosures

201 Husson Ave.
Apt. Noble 8
Bangor, ME 04401
1-945-6715
September 29, 1989

The Hon. Olympia Snowe
Congress of the United States
House of Representatives
Washington, DC 20515

Re: Rural Health Care Hearings

Dear Rep. Snowe:

As was brought out at the hearing in Bangor, both rural and urban elderly suffer many of the same problems in obtaining and paying for health care. Enclosed are photocopies of testimony I presented at the Maine State Legislature's Blue Ribbon Commission Hearing on Health Care Expenditures, when it was held in Bangor. These problems could be experienced, under the present cost containment structure, in both rural and urban areas anywhere in the State of Maine.

Emphasized at your joint hearing with Sen. William Cohen in Bangor was concern over the rejection of reimbursement for both pap tests and mammographies. When I received a rejection for a $7.50 pap test claim, I telephoned my doctor's office and asked if they realized they were giving frivolous pap tests. Of course, the truth is that there are no non-diagnostic pap tests or mammographies. The reason every single one is given is to diagnose cancer at the earliest possible time in an effort to save lives. It is horrifying that those who cannot afford to pay the fee out of their own pocket, as in my case, most of the time, have to face the risk of undetected cancer. My doctor realized that the terminology on the submitted claim is very important. He states that the test or mammography is diagnostic and the claims have been paid. I have friends who have been denied reimbursement for tests related to heart disease, although the fact that heart disease exists has been established. The means of treatment may require further specialized tests. Very few women Senior Citizens that I know have the funds to pay for such expensive tests out of their own pockets, no matter where they live. Are their lives worth less than others just because others have more financial resources

Remember when hospitals were places of healings of a multitude of medical problems? Through lack of common sense in setting up cost containment regulations, hospitals have now become places of discrimination and places where, if a medical problem is not recognized as life-threatening, within a rigid definition, patients are sent home (as Dr. Pelli, pointed out during the hearing) too frequently before they can deal with recovery with no help at home, or, in some cases, cannot respond to mandated preliminary healing schedules of cost containment. Individual physical systems vary in their capability of healing followin even out-patient surgery. There is no doubt that the move to out-patient surgery services is a fine thing--as long as it is remembered that it is human beings who are being dealt with, not inanimate objects, and as long as it is remembered that homemaker services are too frequently not available. To pretend that the hospital or doctor has no responsibility for seeing that some kind of care is provided when "social problems" have not been solved in State Legislature, Congress, or local government, is unacceptable.

I apologize for listing medical problems, but their reality is germane to this subject. I am a 74 year old woman with a severely degenerated spine with a considerable deviation caused by scoliosis, for which I wear a heavy brace. I have tendinitis of both wrists and ankles, wearing braces on my wrists, and often on the worst ankle. I have lymphedema of my left leg with problems described in the accompanying material. I have osteoarthritis which lights up a body scan like a Christmas tree. I have multiple allergies, and asthma which requires medications throughout the day. Most of these medical problems are very painful, requiring considerable pain medication which has had to be increased substantially because of a new develpment of severe pain in the hips and down the legs which has been diagnosed as caused by bursitis. I am in a distressing struggle to try to keep my independence. That independence is devoted to serving others through my writing on social concerns, which includes study and gathering relevant material. I also have a "caring ministry" of programs I present in hospitals, nursing homes, and homes for the elderly. I have had to have surgery numerous times and I am now faced with out-patient surgery on October 10 to try to correct a knee which locks in a bent position with excruciating pain.

I recently had to dial 911 and be taken to Emergency by a fine police ambulance crew. I was sent home by ambulance, after having been told that the District Nurses Association would call me. I have been through this type of thing before. The District Nurses Association people are wonderful, but there are regulations by which they must abide. I went through an absolute nightmare of exacerbation of every one of my already very painful conditions because I had no help whatever. A therapist from the DNA telephoned six days after I had returned home--he had been out of town, he said, and had just gotten the message. To have received home care help, the rules stipulate there must also be home therapy. Again, I must question the purpose of such a rule--why should the two things be tied together? I did not need therapy, I neede help to stay off my feet for seven days, which was my doctor's advice when contacted by the Emergency Room doctor.

I am relating all this because, to date, I have no assurance of having the help I will need when I return from the out-patient surgery. I have a wonderful doctor who will try to see that I am kept in the hospital for a couple of days in order that the healing process may have a good start before I have to go home with so many painful problems and possibly have to, again, manage by myself. It is one thing to send a younger person with no other painful medical problems home to fend for themselves, but to have such unnecessary additional pain be my lot to cu costs, obtaining money that may be irresponsibly squandered elsewhere is both a disgrace to the nation and a definite form of abuse of the elderly. Incidentally, in order to see that I get the care I need, my doctor risks not being paid if the claim is rejected. I know that EMMC staff members want to help, but EMMC faces the same risk of non-payment. Doesn't it seem a reasonable thought that I already have enough problems with which to cope, as do thousands of other elderly both rural and urba so that there could, and should, be some assurance before I enter the hospital with regard to adequate supportive care following the operation? (Cost containment measures allow a 23 hour grace period. I do not think it is out of line to point out that, since I have only one to two hours of household help per week, and take care of myself in every way for 166 hours a week, and since I have suffered the intense spinal pain since I was in my mid-thirties [39 years], and since I definitely am a "contributing citizen," that perhaps a little respite care for me as well as for others who take care of those who are ill, would not be unreasonable. Or, if such an accommodation cannot occur for me, I hope that it will become a consideration in dealing with the many other Senior Citizens who give so much of themselves as volunteers but are only thought of in the context of a financial drain on the nation because they are low income through no fault of their own.)

One last thought which applies to both rural and urban people who must seek aid through social programs. One of the first questions asked is, "Do you have a family?" Whether the person has a family or not is of no relevance whatever to providing aid through programs which are supposed to be provided for all citizens who have a need and can qualify. There is no doubt that it is wonderful when family care can fill a need, but it is pure discrimination to place a burden on families because there is a relationship which other familes with no relatives do not have to bear. I have three sons with families, who help me when they can, but they have their own problems. Other families do not necessarily have good relationships and it is unacceptable that anyone applying for deserved help in traumatic conditions should have to deal with the embarrassment of having to discuss strained family relationships. There seems, also, to be an assumption that every parent has one or more wealthy children to step into the breach. More families would help to a greater extent if credit somehow was allowable for financial help that is given. If families give financial help on a regular basis, it is unjustifiably counted as extra income and the Senior Citizen still winds up in abject poverty. The family should be able to provide a little leeway so that an older person could have just a few of the pleasures in life that most people take for granted. We are not talking about the hard-core poor who take advantage of the taxpayers. We are talking about the fine people who have sacrificed a great deal through the years to help make this nation the wonderful entity it is, but are bewildered to find that no distinction whateve is made between them and the out-and-out chiseler.

I appreciate very much the opportunity to present the viewpoint of a person who has been through great difficulty and has also talked to many other people who have been experiencing the same sort of problems. However, as Dr. Pelli, said to me when I told him I wanted to stand up and cheer when he testified about people being sent home too early from the hospital--said Dr. Pelli,"Let's hope it falls on listening ears."

Sincerely yours,

Elizabeth Whitehouse

(Mrs.) Elizabeth Whitehouse

Enclosures

A RESPONSE TO THE BLUE RIBBON HEALTH CARE EXPENDITURE REPORT

by Elizabeth Whitehouse
201 Husson Ave., Noble 8
Bangor, ME 04401-3240
945-6715

After looking over the draft report on Health Care Expenditures, my great fear is that the frustrating pattern of regulation now in use is going to be continued--perhaps magnified in scope. The present measures of cost containment and shutting off of funds have led to overwhelming stress, stroke-generating frustration, and even to downright heartbreaking situations for elderly patients and for young handicapped people as well. Medical ignorance on the part of bureau employees in many situations compounds the difficulties generated by rules which are also dreamed up without adequate medical knowledge. Patients are often put at risk, and in come cases, the final result has been greater expense rather than cost containment.

One major cause of the frustration is the rule that sounds reasonable but in practise is far from it. The rule is that home care of any kind can only be provided for those who are completely home bound. It is referred to as the "going out the door regulation." It tries to push live human beings into niches with the result of much senseless pain and suffering. A whole separate hearing could be filled with the nightmarish results of the regulation. Here are samples from my experienc

I was recently released from the hospital following shoulder surgery which made it necessary to completely avoid using my right hand. I am a right handed person. I was ambulatory, but having some minimal home personal care was advisable--for having a bath: help in preparing meals, and cutting my food. There is a shortage of such help--if it had been available, it was denied on the strength of the "can go through the door regulation. Oh, yes, I also had to have home physical therapy to qualify for personal home care. I had physical therapy at the hospital and it has been continued, but was denied at home. Why home physical therapy and home personal care are related, I don't know. It didn't matter that I couldn't get my shoes on and tie them with one hand, or that I couldn't put my back brace on and fasten all the straps. It didn't matter that I wouldn't go through the street door to take a shower or that I wouldn't go barefoot to EMMC for physical therapy. No one bothered to explore that there might be extenuating circumstances to put the regulation aside. Tragedy nearly occurred when I tried to take a shower to overcome nine days of hospital sponge baths. I was very fatigued and in considerable pain from my total multiple medical problems. (A plastic bag covered the bandages.) I had my eyes closed against the cascading water. Probably because I was using my left hand, I became disoriented and turned the faucet toward scalding hot water rather than toward off. In my scramble to get out of the tub and away from the scalding danger, I could have ripped out over $2500 worth of delicate surgery and probably would have completely ruined my chances for returning to active performance with the piano. Having a personal home care service for the bath could have prevented such a frightening experience. The requested care wasn't for 24 hours a day, but for short periods for just a few days.

A year ago in April, I experienced the heartbreak of lying on a cot in Emergency for over four hours while the cost containment argument rated over whether or not I should be admitted, since I was experiencing excruciating pain when I tried to walk; lived alone in a second floor apartment, and knew from personal experience that I would not be able to manage alone under the circumstances. Two Emergency Room doctors said they could find no cause for the excruciating pain. X-ray showed a ruptured ankle tendon, but that was not sufficient cause for hospitalization. After entering Emergency, I began to experience even more excruciating muscle spasms in the affected leg. Not one person asked me any questions or gave me a chance to explain that I had a severely degenerated spine with pinched nerves which a neurosurgeon had warned could lead to just such an experience. The admitting staff would not allow me to contact my personal doctor because it was during his office hours. He could have shed light on the subject and given a character reference that I wasn't out for a hospital holiday at taxpayer's expense. My orthopedist was out of town. I felt like I was considered a worthless and troublesome human being, and when I thought of the over 50 years of intensive volunteer work I have done for community and church while serving as the best wife I could be and raising three children, and when it was the truth that I had experienced severe spinal pain since I was in my mid-thirties, and, at the time this happene I was 72 years old and working long hours to serve other people through the beauty of my original music and poetry, photography, and art, it was as though my heart was broken. I cried and cried, and that seemed to make one of the doctors angry--both that I cried and that I wouldn't quietly go home where I belonged. The saving grace in all this was the compassionate attitude of another doctor, whose name I believe was Clement, and the nurse who was in charge of Medicare admissions and had done every thing she could think of to see that I would be given proper care. My orthopedist's associate came in after his office hours, the first opportunity I had to discuss the pinched spinal nerves. Very soon after that I was in a hospital bed receiving the tender loving care that

I surely had merited from the beginning. The fear that Medicare might not pay had done something to ordinarily very caring people that made concern for the patient take a subservient place below the dollar sign. The hospital's patient relations representative to whom I later talked apologized for what had happened. The very wonderful and loving care I received at this same hospital with my shoulder surgery did much to help erase the memory of that nightmare. Nevertheless, there is much wrong with the cost containment mechanism to set such a nightmare in motion in the first place.

Another situation which has led to great stress and frustration is that there is no medical priority for ambulatory handicapped people in the regulations governing homemaker's care. I have had a discouraging three year struggle to try to get just three hours a week of homemaker's help on a long term basis because my condition is chronic; help to do the portions of home care that are helping destroy my already badly damaged spinal joints and other inflamed joints when I try to do such work--such movements as grasping and bearing down with arthritis damaged hands and wrists; bending repeatedly, and piston movements of arms and the bending to run a vacuum cleaner; these will all too rapidly destroy the joints that otherwise could suffice to keep me independently living for some time to come. The alternative is a boarding home for the elder or, of course, living in filth. I could be evicted from my apartment fo accumulated filth. The boarding homes cost from $750 to $900 a month, which neither I nor my family could afford to pay. There are other complications that could send me to the next step, the $2000 and up a month expense of a nursing home. There are waiting lists for both types of homes. I could become a criminal and the taxpayers would pay $1000 a month and up to keep me incarcerated. Somehow, paying $75.00 a month for 15 hours of homemaker's care seems a better bargain all the way around. (COMMUNITY HEALTH & COUNSELING CENTER COULD BE $75.00
(NEW ENGLAND HOME HEALTH CARE WOULD BE ABOUT $138.00

Every day the media proclaims that legislators are proclaiming that the nation just cannot afford adequate health care, eye glasses, dental care; hearing aids. Every day the media services urge the buying of every luxury item one can possibly imagine, as well as absolutely unnecessary snacks, alcoholic and non-alcoholic beverages; personal $3000 spas to relax in after a hard day's work. Sales reports confirm that people are buying all these things, totalling in the billions. It isn't that we can't afford such important things--the truth is that there is a desire for Christmas every day, and who wants dental work or eye glasses for Christmas? The elderly do, that's who!--and just once a year would be fine. Legislators and taxpayers would do well to remember that old saying, "There, but for the grace of God, go I."

I am speaking at the request of many people who have had bad experiences and say they cannot speak for themselves. I've also been encouraged to speak by several doctors, nurses, social workers, and the personnel of health agency staffs and homemaker and home nursing-care providing agencies. An analogy should help make graphically clear the way cost containment looks to a multitude of people. This is what the management of an auto manufacturing company would say to their customers under the cost containment scenario. "Because manufacturing costs are getting out of hand, this car you are purchasing will have only three wheels--new regulations, you understand. These wheels may have tires that leak, but testing is an expense we are avoiding to keep costs down. Oh,yes, we hope you will get by all right on your own out on the highway without a steering-wheel assembly, but costs must be kept down, remember. What happens to you after you leave here is, of course, not our responsibility. Don't rock the boat by protesting these cost containment measures--that's liberal; unAmerican. it isn't our fault the taxpayer-stockholders are demanding that these stringent measures be applied to the elderly, the poor, and the handicapped."

In all seriousness, the present system seems to take the cost containment scissors and begin snipping without adequate proof that the parts snipped are really the cause of excessive medical expense. I find it impossible to believe that the reasons for the mounting costs can reliably be determined without the legislative Blue Ribbon Commission sitting down with appointed representatives of hospital administrators, physicians and surgeons, and other health care providers to conduct non-confrontational; non-adversarial, mutual-aid dialogue which will get at the truth. It will be made clear where the points of waste and inefficiency are if the medical people are guilty as inferred, or it will reveal other levels where there is waste. Or it may be made clear that these health care providers are doing a remarkable job under very difficult circumstances, and taking undeserved blame. The answer may lie somewhere in between, but it is an answer that has not been, but must be,explored.

ADDITIONAL HELPFUL INFORMATION FOR BLUE RIBBON COMMISSION

Another example of the "can go out the door" or homebound rule being applied inflexibly concerns a man who is virtually confined to his home with medical problems, yet has been benefitting from being transported to the Adult Day Care Center where he has companionship with other people in the same condition, to help end the terrible isolation and loneliness of people who have difficulty in being normally ambulatory and having social contact with others. Now he is in a situation requiring that a home nurse come and change his catheter daily. He was told (my information is from an agency providing assistance to the elderly and a home health care bureau) that he could not go out to the Adult Day Care Center because "going through the door" made him ineligible for the nurse to come to his home for the brief catheter changing service. Changing the catheter has to have priority, if a choice must be made, but by all the rules of compassion and common sense, it surely could be arranged that the man could have both and not break the taxpayer's bank.

An example of the "cost saving" of omitting medical tests when a doctor feels the diagnosis is so obvious that no test is necessary, and the reality of what may result in expense is shown by my own experience. The first test omitted was over forty years ago, and was not under current cost containment regulations, but forty years of situations of error related to testing gives a good idea that the matter of testing is far more complicated than is now being recognized. The omitted test was to identify a supposed case of hyperthyroidism. The doctor felt the signs were so obvious that the expense of a metabolism test was not necessary. He treated me with potassium iodide, which apparently did not harm and the "obvious" signs dissipated. Later a more cautious practitioner performed the metabolism test and declared that he did not believe that the thyroid had ever been over-active. Again, just a couple of years ago, the signs were so "clearly obvious" in the words of an endocrinologist that he was sure that the new diagnostic blood test would confirm his suspicion. He was quite baffled that no hyperthyroidism existed. The measures necessary to correct hyperthyroidism are quite drastic sometimes. Therefore, testing even when the diagnosis seems obvious can be the better part of wisdom in serious matters.

That situation resulted in little harm to me, but in another situation of failure totest (spread over a period of years), the result had the potential for tragedy. I have a medical condition of my left leg called lymphedema. The lymph nodes do not fulfill their normal function. Fluid accumulates and bacterial infections are not filtered out, with alleviation of both of these conditions the function of normal lymph nodes. The excess fluid makes the leg very uncomfortable, sometimes burning and painful, and the sudden onset of the subcutaneous infection (usually staph) called cellulitis, in some cases is mild, but with me it usually sweeps through my system and makes me very ill unless there is anitbiotic treatment. Both because I am allertic to most forms of antibiotic and because I usually have to be hospitalized, great care is taken for prevention,and attention as soon as possible is urgent. A recent episode with antibiotic therapy caused such severe asthmatic bronchitis that surgery had to be postponed and when hemoptisis grew worse and worse and there had been unusual fatigue and a quick loss of considerable weight, a bronchoscopy was performed. Although the symptoms are different, the lymphedema-cellulitis combination and phlebitis have been confused in my case repeatedly. In 1979 I was hospitalized for excruciating spinal pain; for a bladder infection, and what was first termed cellulitis was changed to a diagnosis of phlebitis.

Partly, I believe, because previous doctors had diagnosed the fluid filled and erythematic condition as phlebitis, no test was done and the condition was assumed to be phlebitis. Coumadin was prescribed to thin the blood and supposedly to help reduce the blood clottinng blockage. After I was released from the hospital, a laboratory nurse came to draw blood--twice a week at first and then once a week--to make sure that the blood thinning was not out of contol. There was considerable expense involved in this. Next there was some intestinal bleeding and a banding process was performed to stop it. The doctor had somehow overlooked the fact coumadin was being administered. The banding process led to excessive bleeding which required out-patient surgical fulgeration to halt. The hemorrhaging became very great. My doctor was out of town and the covering doctor told me to stay in bed and wait until my appointment with my own doctor on the following Tuesday. I tried my best to do as he said, but the bleeding was so great that I finally collected evidence in a pint measuring cup and called the covering doctor to ask if a pint of blood was enough of an emergengy to have me admitted to the hospital. Admission was arranged immediately. Several more fulgerations were necessary and six blood packs were administered. I have bad reactions to transfusions which was bad enough, but all this led to the fact that after the news surfaced of AIDS on occasion passing on the virus to innocent people, at age 72, I was faced with the degrading necessity of going to the Sexually Transmitted Disease Clinic to be tested for AIDS exposure. This had happened to me within the nine to ten year period when it was realized that the sleeping virus might become evident. The expense of omitting a test that would have confirmed or ruled out phlebitis led to a horrendous amount of expense, to say nothing of what I was personally put through as a result of the ommission. Fortunately, the blood test proved negative.

Item 6

October 4, 1989

RECEIVED
OCT 12 1989
OLYMPIA SNOWE, M.C.
WASHINGTON, D.C.

Congresswoman Olympia J. Snowe
c/o Aging Hearing
P.O. Box 1938
Portland, Maine 04104

Dear Congresswoman Snowe:

The following are my comments regarding rural health care for the elderly, to be included in the records of your recent hearing on these issues. My remarks are directed toward the issue of quality of rural health care.

Those directing legislation governing rural health care will be well advised to remember the following immutable facts about rural America:

1. Rural Americans strongly prefer to be cared for near home. Most often, they demand it, and will go to a distant tertiary center reluctantly, if at all. Centralizing health care, even in the best of all systems, will mean little if people will not use the system.

2. Knowledge of health care provider systems is very unsophisticated in rural America, and is likely to remain so. A doctor is a doctor in the country, and few elderly patients can define the differences between osteopath and orthopedist, intern and internist, family practice specialist and general practitioner, chiropractor and M.D.

3. Accordingly, people will use whatever is available near home, what is most affordable and whatever system is of easiest access. They will assume that someone, the Federal Government or the medical profession, has provided for quality control (which of course is not true) just as someone watches out for the consumer in the automobile showroom (which is far more likely).

4. For most Americans rural or urban, care at tertiary centers results in great cost in terms of travel, overnight stays, meals. The emotional burden is even more costly; witness the dying grandmother in a rural hospital who has friends and family nearby, and is permitted to have her husband stay with her at night in a cot next to her. This basic decency for the dying patient is impossible in the large urban medical centers.

Given these facts, what are the solutions to the question of better health care for the rural elderly? These are the possibilities:

A. Centralize health care, closing most rural hospitals and forcing people to the large centers.

B. Promote HMO's and PPO's in rural America, funnelling patients into a system designed ultimately to direct patients to the urban centers.

C. Keep things as they are now. Forget about legislation.

D. Legislate to improve rural health care, to keep it viable, and to ensure its quality.

Centralizing health care (solutions A and B) is not a practical option. An example:

An elderly patient with Hodgkin's Disease (lymph gland cancer) requires frequent and complex chemotherapy, which can often cure the cancer. Yet too frequently all cancers are deemed hopeless by the public, chemotherapy too toxic to endure, and the patient declines therapy or is lost to follow-up. Keeping sophisticated medicine close to home allows better patient education, better health care delivery. And such care can be less expensive for third party payers and still be of the highest quality.

If health care in the hospitals in Norway, Farmington, Skowhegan, Rockland, and Dover-Foxcroft is comparable in quality and complexity of care to urban centers and yet is 25-35% less expensive, what can be the rationale for centralizing health care?

If therefore, a decentralized system of care is deemed best, we are left with solutions C or D above. What is wrong with solution C, i.e., leaving things as they are?

1. Rural hospitals are withering under excessive regulation, especially in Maine.

2. Quality of care varies tremendously region to region in rural America. The HCFA-sponsored PRO system is still a cost-containment organization, despite rhetoric to the contrary. There exists no universal standard for credentialling of privileges or procedures in any American hospital. The JCAHO does not guarantee quality in this area. Although a trained surgeon almost always removes a diseased appendix these days, a diabetic in coma may often be cared for by a physician only partially trained and not certified in any appropriate specialty. Any doctor with one or two years of training beyond medical school can advertise "specialty interest" in diabetes or diseases of the heart and circulation, for example, and the elderly falsely assume this implies quality.

3. Rural health care is too often relegated to inadequately trained physicians, or to physicians who practice more complex medicine than they are competently trained to do. Medical school loans, malpractice litigation, and the glamour of the university with high salaries siphon off qualified primary care practitioners needed for the rural elderly. For example, the U.S. needs 2500 more internists than are being trained as of 1989, yet is training 5500 more cardiologists than it needs.

If we agree that the goal of new legislation is to make rural health care better, and to preserve it as a viable option, what should be done?

1. Reward excellence in rural hospitals through incentives such as de-regulation. Poor hospitals should be regulated out of existence, in my estimation, or be forced to improve care. Neither is happening in Maine, nor will it with the present system.

2. Send notice to specialty medical boards that if they do not get involved in the credentialling of procedures and privileges for physicians, the government will. No physician who does not have board certification should be admitting patients to a hospital. Unsupervised family practitioners should not be taking care of patients with heart attacks. Specialists, whether M.D. or osteopath, should take the same certifying examinations. Separate standards for D.O.'s and M.D.'s compromises quality. Chiropractors should not be getting third-party payments and the endorsement that implies.

3. Use the Wennberg data and the example of Maine's Medical Assessment Program as developed by Dan Hanley of Brunswick to monitor quality of health care and direct a more unified delivery of care, performance of procedures and surgery, and hospital lengths of stay. Pouring money into the PRO system to ensure quality is wasting money.

4. Study hospitals that have been successful both in terms of quality and cost containment, such as the hospitals in those communities mentioned above. How do they do it? How can a hospital with the fourth highest complexity of care rate in Maine (Stephens Memorial Hospital in Norway) and one of the lowest cost per admission indexes and a rate of remuneration far below the mean do the seemingly impossible? Why are other hospitals failing to keep pace? There are answers to these questions. They are not always politically attractive answers, but they need to be addressed.

5. Keep cost-containment in proper prospective. Its war-cry is fueled by the business sector, whose funding of private insurance suffers in great measure from Medicare and Medicaid short-falls. And the budget for the Stealth Bomber (at 69 billion dollars for 132 of them) would pay two-thirds of the Medicare budget (97.7 billion) for a year.

6. Aggressively support the reassessment of physician remuneration for cognitive services. Procedure-oriented physicians, and opthalmologists and radiologists as well, are vastly overpaid. If you do not attract certified, well-trained primary care physicians to the country, that void will be filled by incompetent physicians.

A retired farmer with chest pain may not survive the one hour trip to a medical center. He needs excellent care close to home. Such care is possible in the rural setting. It is being done right now in many areas in Maine, by physicians for whom quality of life-style is more important than big-city salaries, by hospitals working under burdensome regulation, by trustees working for nothing, by nurses deeply committed to their communities and their patients.

When someone from the city disparages rural health care delivery and points to a marginal band-aid station somewhere, point to Maine's best rural hospitals. Show them what can be done.

Yours sincerely,

Michael A. LaCombe, MD

Item 7

Downeast Association of Physician Assistants
c/o RHCM, 3 Commercial Street, Augusta, Maine 04330 • (207) 622-9252
Est. 1977

TESTIMONY
SENATE SPECIAL COMMITTEE ON AGING
HOUSE SELECT COMMITTEE ON AGING

Thank you for the opportunity to address this hearing. As an active and growing part of the health care delivery system in Maine, we too are concerned about Maine's underpriviledged, rural, and elderly health care consumers, and wish to play an active part in formulating services to this patient population.

As some background information, Physician Assistants (PAs) have been a practicing entity since the early 1960's, when the first classes graduated, composed chiefly of experienced corpsmen desiring to use their medical skills in civilian life. PAs are trained members of the health care team, practicing on a physician model, under the supervision of a licensed physician. There are 51 programs in the U.S., accredited by the Committee on Allied Health Education and Accreditation (CAHEA) on standards developed by a special committee of medical associations, including the AMA. Upon graduation, PAs may take a national certifying exam, and most states (including Maine) require this certification. On successful completion of this certifying exam PAs are known as certified, or PA-C, and must complete 100 hours of continued education every 2 years, and a recertifying exam every 6, to maintain certification. PAs are educated to obtain patient histories, order appropriate lab, x-ray, and/or other studies necessary to make the diagnosis, and, on diagnosing the problem, determine treatment. In many states, including Maine, PAs are able to prescribe medicines.

Practice settings vary according to state laws, the physician's scope of practice, and the training of the PA. They may be found from remote rural areas to large urban centers, in offices, hospitals, clinics, HMO's, Armed Forces, federal agencies and correctional facilities, even the White House. Most work in family or primary care settings, but some specialize into surgery, cardiology, psychology, etc.,. Salaries depend on the specialty, area, and hours worked (including "on call"), and in 1988 averaged 34,000 dollars annually. Thus, by filling many of the standard duties otherwise performed by the physician, a PA allows the doctor to spend more time with more complex cases and emergencies, for less.

It has been proven that PAs offer cost effective health care in studies done by HCFA in 1988 and earlier. Salaries and malpractice insurance are less than the physician counterpart. Educating is also less costly and time consuming. It is an average 2 year process; the first year is didactical and the second is clinical in experience. Cost of training varies greatly from private schools, like Yale, at approx. 20,000 dollars , to state universities, at approx. 10,000 dollars, for the 2 years. Postgraduate internships are also available in specialty areas on a very competitive basis as there are so few.

In the state of Maine, there are currently 210 PAs registered with the State Board of Medicine; 20 percent of these working in rural Maine, some delivering vital services at Health Manpower Shortage Areas (HSMAs). As of a Feb. 1989 state survey, the average salary was 34,000 dollars. Through hard, diligent work PAs have very good enabling legislation in this state, and a broad based formulary from which to prescribe medication. The general attitude in this state is "Pro-PA", as it is recognized by the doctors "in the field" what a relief from isolation it can be to have a physician extender there to share call coverage, when another doctor may not be financially feasible.

One problem faced by PAs wishing to supply the state's elderly with their skills is the current Medicare coverage. In 1986 and again in 1987, Congress expanded coverage of PA services to a number of practice settings. Currently, physician services provided by PAs in hospitals, skilled nersing facilities, intermediate care facilities, HSMAs, and for assisting at surgery are covered by Medicare Part B. on a discounted fee basis. These services must be performed under employer supervision, and payment is to the employer of the PA. However, in the state of Maine especially, there are many rural clinics that are not designated HSMAs, and the PAs employed at these sites are unable to be reimbursed for services to Medicare recipients, unless the supervising physician is directly on site. At these rural settings this is not always feasible or practical, thus defeating the purpose of the "physician extender", and serving as a disincentive to the employment of PAs. This decreases the access to health care for the very people we need most to reach, the 14 percent of Maine's population over the age of 65. Presently there is federal legislation introduced to provide expanded Medicare Part B coverage for PA services. H.R. 1175 was jointly referred to the House Ways and Means Committee and the Energy and Commerce Committee. S. 461 was referred to the Senate Finance Committee. The PA profession is requesting that all Senators and Congressmen show their support for the profession by cosponsoring the appropriate bill.

Another area of concern, especially in rural Maine, is recruitment and retention. Only 20 percent of the state's PAs are servicing rural Maine, roughly 70 percent of the state. These jobs are in areas considered undesirable because of professional and personal isolation, and compensation factors are not equilibrating. It must be said, however, that mid-level practitioners have a lower attrition rate than their physician conterparts and become a welcomed community member in most instances. Rural communities that are not large enough to support 2 physicians could rely on the doctor-PA team to provide 24 hour coverage. A PA joining a doctors team can afford the clinician group more time away from the stresses of of isolation, and back into their own personal lives. Though at a lower rate, however, PAs are not free. Even the reduced cost can be a burden to communities, and lower salaries that may be affordable for the clinics are not always competitive with urban markets.

Until 1983, NHSC sponsored mid-level practitioners at HSMAs. A solution may be to support loan repayments again. This past year the state legislation killed L.D. 1553, a loan forgiveness bill for mid-level practitioners. The Downeast Association of PAs (DEAPA) would request this issue again be addressed in upcoming legislation. Another alternative might be sponsorship of students to a PA program in the Northeast region (the nearest is at Northeastern Univ. in Boston MA), with funds from the Health Occupation Training Program. By state or federal support for PA training, the graduates can be recruited to rural sites for repayment, in similar fashion to NHSC. A third possibility would be the institution of a PA program in the state. This would give the profession even greater visibility and make training more accessible. Retention is a difficult issue and boils down to one factor--money. Additional funding would make salaries competitive with other markets and/or provide for the hiring of additional physician extenders to a stressed clinic population.

Lastly, the issue of L.D. 1322, the state health insurance bill for the underpriviledged. As one can see, physician extenders are important members of the health care team. Throughout the state, PAs are treating the over 130,000 Mainers who lack insurance, and soon may be eligible for the new state policy. DEAPA requests that all mid-level practitioners be included in the reimbursement coverage for the services that they provide to this population.

Again, thank you for this opportunity, faithfully submitted,

Amy Strainer PA-C Vice President of DEAPA

Item 8

EMERGENCY MEDICINE ASSOCIATES
39 PLEASANT STREET • MECHANIC FALLS, MAINE 04258 • (207) 345-3311

Dear Senator Cohen and Representative Snowe,

Please accept this written testimony for the access to medical care hearing held September 18, 1989 in Bangor, Maine.

Who am I?

I, Pamela P. Bensen, MD, FACEP, am a trained board certified Emergency Physician. I have practiced Emergency Medicine in Maine since 1973. I have practiced 16 years at St. Mary's Hospital in Lewiston, 4 years at Bath Memorial Hospital in Bath, 2 years at Regional Memorial Hospital in Brunswick, and 3 months at Miles Memorial Hospital in Damariscotta.

I am the president of Emergency Medicine Associates, a group of 17 full time and 33 part time physicians staffing the above mentioned Emergency Departments (ED's). I practiced Emergency Medicine full time until August 1989. I now practice part time, filling all uncovered shifts at the four hospitals. I have helped cover shifts at Central Maine Medical Center (Lewiston), Kennebec Valley Medical Center (Augusta), Sebasticook Valley Hospital (Pittsfield), and Stephens Memorial Hospital (Norway). I care for approximately 5,000 emergency patients a year.

Why am I submitting this testimony?

Access to primary care is a genuine problem for many Americans. Now, more Maine citizens are having trouble getting into the medical care system. As an emergency physician I see the end result of this problem.

For the last 16 years I have noted expensive misuse of the ED and of the Emergency Medical Services (EMS) System. I have worked with patients, hospitals, social service agencies, legislators, and third party payors to educate patients on the prevention of emergencies and the proper use of the ED. I have tried to decrease the number of patients seeking medical care from the ED inappropriately. However, it is becoming harder for Mainers to find care outside of the ED. The ED census is climbing, true emergencies are competing with primary care patients for ED resources, and emergency personnel are facing problems previously seen only in urban areas.

Why are patients seeking more care in the Emergency Department?

We are seeing spiraling numbers of patients seeking care in Maine's Emergency Departments for the following reasons:

1. There are less physicians. Patients, unable to find a regular, primary care physician, ignore simple medical problems until they escalate into severe difficulties requiring emergency care.

2. Less physicians are available on a timely basis. Patients in need of care are unable to get a timely appointment with a physician. The few physicians accepting patients are booked months in advance.

3. Physicians are less able to spend time reassuring patients. The art of medicine is a luxury when physicians are scarce. Patients seek reassurance in the ED, when unable to get it from their private physician.

4. Physicians expect to see patients they treat. The malpractice climate makes it less possible to treat patients, even well known ones, with out seeing them. Physicians will not treat over the phone and refer patients to the ED if their offices are booked.

5. Maine's lack of mass transit systems forces patients to depend on private transportation. Patients with personal physicians, unable to find transportation, during "routine physician office hours", come to the ED when parents, spouses, children, neighbors, etc, return home from work and can provide transportation.

6. Emergency Physicians are mandated by Federal law to accept all patients. Uninsured patients face financial barriers to primary care. Low physician reimbursement is forcing private physicians to refuse patients with Medicaid, Medicare, or no insurance. These patients seek the only available care, the ED, for problems which could be treated by a physician in the office.

   A 1984-1985 survey conducted by the National Opinion Research Center for the Health Care Financing Administration found uninsured patients accounted for 19 percent of the visits to emergency physicians, compared with 10 percent for other physicians.

7. Society no longer allows an individual to be ill unless certified by a physician. Industry and schools require "notes from the doctor" when an employee or student returns to work or school. Patients seeking notes for self limiting illness come to the ED.

8. Ignorance of, and inexperience with, illness and injury prompts patients to seek unneeded medical care. The American public knows little about the human body, illness, and injury which produces anxiety and inability to appropriately care for one's self.

9. Used to instant gratification, Americans want medical problems cured immediately with minimum inconvenience. America wants a "quick fix" and time is not given a chance.

10. Americans abuse their bodies, expect physicians to fix the results, and want insurance companies to pay for the repair. People continue to smoke, drink, and use drugs.

    Smoking damages the heart, lungs, and blood vessels. The resulting illnesses, heart attacks, emphysema with respiratory distress, and strokes, are emergent in nature.

    Alcohol is involved in 50% of fatal motor vehicle accidents and plays a large part in domestic violence, child abuse, falls, and other injuries. On Saturday night in the ED half of the patients over 15 have alcohol on their breath. Millions of patients with alcohol related illnesses, DT's, psychosis, hepatitis, cirrhosis, and liver failure, seek care in ED's yearly.

    Drugs misused, abused, and used accidentally result in allergic reactions, over doses, poisonings, and other acute illnesses.

11. Failure of the American public to prevent serious injury. Americans accept a tremendous bill for injuries resulting from inadequately protected human bodies engaging in known high risk behavior. We can no longer afford this costly practice. We must decrease the disastrous economic, human, and resource strain these injuries place on the country and health care system.

    Speed kills and injures. There was a significant drop in motor vehicle trauma when the national speed limit was dropped to 55mph to conserve gasoline. This trend was dramatically reversed the day the speed limit was raised.

    Seat belts save lives and prevent injuries. Statistics show Americans would save significant dollars if all persons in motor vehicles were properly restrained. Yet we continue to allow citizens to drain the financial and human resources by permitting them to travel unrestrained.

    Passive restraints save lives and prevent injuries. Although they represent a cost to the individual, passive restraints save money each time a person is protected from severe injury.

    Motorcycle helmets save lives and prevent injuries. Statistics prove protective head gear for motorcycles, ATV's, snow mobiles, and even bicycles prevent costly head and neck injuries.

Why are there less physicians available to Maine citizens?

The USA is facing a decrease in the number of physicians.

1. Medical school tuition. Medical school tuition has gone from $1,700 in 1966 to as high as $20,000 a year. Changes in graduate medical education payments to medical schools and teaching hospitals and decreasing resident physician working hours, a long over due improvement in our medical education system, will increase this price tag.

2. Attractiveness of alternative careers. College students no longer view medicine as an attractive career. In the past 1 in 10 medical school applicants were accepted, now it is 1 in 1.1. College students aren't applying to medical school because the cost (over $100,000) and length of education (6-10 years after college), physician hours (60-100 hrs/week), fear of malpractice suits, decreasing physician incomes, decreased physician job satisfaction, public dissatisfaction with physicians, and the availability of higher paying, more rewarding jobs prompts them to opt other careers.

3. Loss of control. Physicians are experiencing less control over issues for which they are held responsible. Although physicians are accountable for care given, multiple agencies, PRO's, QA committees, utilization review committees, third party payors, HMO's, PPO's, Medicare, Medicaid, pharmacy committees, etc, dictate how medicine will be practiced, regardless of the individual patient's need. Physicians finding themselves in this catch 22 are looking for alternative practices or careers.

   Example: 11pm on a cold, icy, night in Maine, February 1987, an 85 year old man, blind in one eye, who lives alone, and gets up 5 times a night to go to the bathroom, cannot be admitted to the hospital with his broken right arm, because the rules say so.

4. New medical methodologies are directly related to cost savings not to quality of care. There is no research supporting fiscally mandated changes in medical care which document improved outcomes for the patient. Fiscal decisions ignore the patient's psychosocial needs and many impede healing.

5. Increasing hassle for decreasing reimbursement. Physicians are experiencing escalating practice costs, growing paperwork, and decreasing reimbursement for services rendered to patients. Large numbers of physicians leaving the practice of medicine are training for other careers (one of our physicians will be a civil engineer), retiring early, entering medical related businesses (medical equipment sales, hospital inspection teams), and going to third world countries.

The decrease in rural physicians is also due to other concerns.

1. Medical school loans. Primary care physicians with loans in excess of $100,000 at age 27-32 are not able to set up practices with incomes of $35,000 a year. The annual interest on those loans is between $8,000 and $13,000 a year. Medical school loan programs encouraging physicians to practice in rural states in exchange for "forgiveness" of the loans have been phased out. Now physicians seek higher pay in other states.

2. Litigation psychosis. Physicians, fearing litigation, choose to practice in "protected environments", in cities and large hospitals, where specialists are available to help if a patient gets into trouble. Even physicians electing to practice in a rural environment, often limit the practice to avoid high risk problems, i.e. the trained OB/GYN who does not deliver babies.

3. Scarcity of specialists. Some rural specialists, willing to practice high risk specialties, are unable to recruit a second physician, and find it impossible to be on call 24 hours a day. They then leave, cease to practice the specialty, or leave days uncovered.

4. The business of medicine. Physicians, trained to practice medicine, have no interest or training in business. The intrusion of third party payors into the patient-doctor relationship and the resulting paperwork has forced physicians to become businessmen. Group practices, with physician employees and business managers to handle the business of the practice are attractive to physicians but seldom found in rural areas.

5. Indigent care. An estimated 37 million Americans have no health benefits. These uninsured individuals (62 percent in families with incomes below 200 percent of the federal poverty level), residents of rural states, add to the financial burden of rural physicians, who must limit the number of indigent patients cared for in their practices. ED's are the last resort, providing access to health care for those without health insurance.

The decreasing number of physicians in Maine is exacerbated by other problems.

1. Malpractice cost. A first year Maine physician pays $4,000 to $40,000 a year for malpractice, depending on the specialty. With claims made insurance, the only kind available, the premium gets larger each year and rivals premiums in states where the cost of living and physician reimbursement is significantly higher. To support this payment the Maine physician must see more patients or work more hours than in other states.

2. Lack of malpractice insurance for part time physicians. Maine physicians cannot contribute to the physician work force on a part time basis because the malpractice premium is the same as for a full time physician.

3. Lack of occurrence insurance. If a physician decides to move s/he must pay a malpractice reporting endorsement or "tail", $5,000 to $50,0000. This "tail" discourages physicians from coming to Maine for a year or two to try out rural practice. If they don't come, they can't stay.

4. Exceedingly low Medicaid reimbursement. The per patient cost of malpractice in Maine easily exceeds the Medicaid emergency physician per patient payment of $9.

What measures can the Federal government take to improve access to medical care for Maine citizens?

1. Increase primary care availability. Initiatives must be developed to make primary care services more readily available to all Maine citizens. College students must view medicine as an attractive career. Mechanisms to finance medical education need to be developed. Qualified medical students interested in practicing in Maine must be encouraged by student loans with forgiveness clauses, if they are charged tuition at all. Medical education must be made shorter, more effective, and more efficient.

   Resident and physician educational programs must be shortened. The fear of malpractice suits must be alleviated. Physician income and security needs to stabilize. The public must re-establish a relationship with physicians so students don't opt for other careers.

2. Increase physician control. America cannot afford to have physicians seeking alternative practices or careers. Physicians need control over issues they are held responsible for. If physicians are accountable for care given, no agency, PRO, committee, or third party payor should dictate how medicine will be practiced.

3. Show cost saving methodologies do not effect quality of care. Fund research of fiscally mandated changes in medical care to document the outcome for the patient. Make fiscal decisions including consideration of the patient's psycho-social needs.

   Stop letting non-physicians mandate patient care.

4. Develop a medical transportation system to assist patients dependent on private transportation. Provide transportation during "routine physician office hours" for patients with physicians.

5. Mandate primary care. Only Emergency Physicians are mandated to accept every patient. All physicians should participate in a similar system so uninsured patients don't seek ED care for the flu, colds, and sprains which could be treated by a primary care physician in an office setting. An equitable system of physician reimbursement would prompt private physicians to see patients with Medicaid and Medicare.

6. Educate the public. Education about illness could prevent unnecessary physician visits and make public expectations about medical conditions more realistic.

7. Tax Americans who continue to abuse their bodies, despite education to the contrary. Cigarettes, alcohol, and drugs should be taxed to pay for specific health problems related to these abuses, i.e. heart attacks, emphysema with respiratory distress, strokes, motor vehicle accidents, domestic violence, child abuse, falls, other types of injuries, DT's, psychosis, hepatitis, cirrhosis, liver failure, acute allergic reactions, over doses, and poisonings.

8. Mandate reasonable measures to prevent serious injury. Drop the national speed limit to 55mph, enact universal seat belt legislation, require passive restraints in new vehicles, and require protective head gear for motorcycles, ATV's, snow mobiles, and bicycles. Save health care dollars.

9. Decrease hassle in physician reimbursement. Help physicians decrease practice costs by simplifying the reimbursement system. Savings to the system could be used to reimburse primary care physicians better.

10. Alleviate litigation psychosis. Create a reasonably "protected practice environment" so physicians can practice in any state and not avoid high risk problems. Develop a fair administrative malpractice system which eliminates high pay outs to lawyers.

11. Develop incentives for specialists willing to practice high risk specialties in rural communities. Programs could include tax breaks and relief for physicians on call 24 hours a day every day.

12. Help physicians decrease the business of medicine. Physicians have no interest in business. Decrease the intrusion of third party payors into the patient-doctor relationship, streamline the paperwork and help physicians develop rural group practices.

13. Decrease indigent care. Support initiatives to make primary care services more readily available by assuring adequate payment for non-emergency primary care services under Medicaid and proposals for the uninsured. Reimburse physicians, or give them a tax credit and malpractice immunity, for caring for the indigent. Decrease the financial burden to rural physicians who care for indigent patients in their practices.

14. Decrease the cost of malpractice. Make sweeping reforms in the liability insurance market. Reinstate contract law, impose federal insurance laws, initiate an administrative system for malpractice case review, and make occurrence and part time policies available.

15. Make Medicaid reimbursement competitive. Improve reimbursement levels, expand benefits, extend eligibility, develop public programs for the low income and others who do not benefit from employer-based plans, and increase the linkages between the public programs and employment-based plans for low income workers.

    Special programs may be needed to address the uninsured and Medicaid populations, who tend to obtain less timely and less reguler primary care. We may need to support physicians or develop public clinics and encourage patients with primary care needs to seek services in these sites, rather than in ED's.

16. Develop education programs. Education should improve patient understanding of where to obtain appropriate services and how to decrease health care costs while improving the quality of care.

17. Mandate health care coverage. Develop legislation requiring employers to offer a minimum set of benefits to workers and their families to decrease the number of uninsured unable to find physicians for care.

18. Pay physicians adequately for services mandated by law. State and federal policies have increased the responsibilities of physicians and hospitals to fill gaps in the health services delivery system. Since 1986, the Congress has required every patient presenting to an ED be given a screening examination to determine if an emergency medical condition or active labor is present. This law requires necessary medical treatment but makes no provision to pay for it.

As an Emergency Physician, I see patients with no alternative but to come to our ED for care and no resources to pay for the visit. Patients needing emergency services should be cared for regardless of their insurance status.

ED's are important access sites for many patients. ED's are required to provide emergency care. Providing this care results in significant financial shortfalls.

Please take steps to legislate safety and responsibility for abusive behavior. Spell out emergency coverage under federal health plans. Include emergency services among the core services provided in health plans. Develop a better system for Maine people to get appropriate medical care for un-preventable problems. Improve reimbursement for emergency services so EMS systems, hospital emergency departments, and emergency physicians can continue to provide the safety net that meets medical needs of patients unable to obtain care elsewhere.

Working together we can make major changes to provide medical care for individuals who would otherwise not receive care.

Thank you.

Respectfully submitted,

Pamela P. Bensen, M.D., F.A.C.E.P.